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MEDICARE DISCOUNT DRUG CARD: MEASURING THE SAVINGS

FORUM

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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CONTENTS

	Page
Opening Statement of Senator Larry E. Craig	1

PANEL OF WITNESSES

Mark McClellan, director, Centers for Medicare and Medicaid Serivces	2
Jim Firman, president, National Council on the Aging, chair, Access to Benefits Coalition	12
Sharman Stephens, director, Planning and Policy Analysis, Office of Research and Development Information, Centers for Medicare and Medicaid Services	14
Mary Grealy, president, Health Leadership Council	33
Robert Helms, resident scholar and director of Health Policy Studies, American Enterprise Institute	42
Julie James, principal, Health Policy Alternatives	97

APPENDIX

Study submitted by the Lewin Group	169

FORUM: MEDICARE DISCOUNT DRUG CARDS: MEASURING THE SAVINGS

THURSDAY, SEPTEMBER 23, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The forum commenced, pursuant to notice, at 2:39 p.m., in room SD–628, Dirksen Senate Office Building.

OPENING STATEMENT OF SENATOR LARRY CRAIG, CHAIRMAN

The CHAIRMAN. Well, ladies and gentlemen, thank you for your patience. Traffic—well, those of you who traffic Capitol Hill understand the congestion and the frustration today, and then, we had the prime minister of the provisional government of Iraq on the Hill, and that has created another traffic problem. But most are assembled, and the rest are on the way. So why do we not get started?

Let me say good afternoon to all of you and welcome you to what I think is a very valuable forum. The drug discount cards and measuring the savings of those cards; of course, this forum is one of several that the Special Committee on Aging here in the Senate has hosted.

We have convened today's forum to take a hard look at the facts, facts about the new Medicare prescription drug card program and the real savings it offers to America's seniors. It is no secret that there has been some skeptical chatter about the program, but the facts, I am pleased to say, speak louder than the words. First, Medicare administrator Dr. Mark McClellan is with us. He is here to announce fresh Medicare data showing clearly that the drug card program continues to provide seniors very significant savings and that these savings are solid and improving.

But let us not just take Dr. McClellan's word for it. Also joining us are representatives of three major independent studies conducted so far on the drug card program, all of which confirm the serious savings available under the program. As anyone familiar with the world of health care policy would agree, the organizations affiliated with these studies are among the most respected in the field, namely, the Kaiser Family Foundation, the Lewin Group, the American Enterprise Institute, the Health Care Leadership Council and the Health Policy Alternatives. Needless to say, when expert groups as diverse as these all come out in general agreement, I think it is safe to say that we are on to something or at least certainly on the right track.

I am also pleased that today's discussion also coincides with this week's announcement that Medicare will soon launch a new program to vastly accelerate enrollment of lower-income seniors, those who are eligible for the additional $600 in cash assistance this year, and another 600 next year. Now, this program is not perfect, and yes, there is some confusion. But this is normal. I am sorry to say in a new program. How many of you have always wanted to rush out and buy a brand new car first one off the line? Most do not. Most much prefer that the marketplace work with it for a year. But in this reality, that does not work. Getting people enrolled and working to get people enrolled refines the program and develops the program.

Finally, I believe it is also important to look ahead. Today's drug card program is just the beginning, a stepping stone, if you will, toward implementation of the full prescription drug benefit less than 2 years away. I hope our panelists can comment on the lessons that we can learn today as we prepare for the tomorrow of 2006 and beyond.

Unfortunately, neither my schedule or Dr. McClellan's schedule will permit us to stay for the balance of today's discussions. However, it is a pleasure to welcome all of you on our panel to be with us today, and we look forward to your contribution.

The CHAIRMAN. Now, let me introduce the director of CMS, Dr. Mark McClellan. Mark.

STATEMENT OF MARK MCCLELLAN, DIRECTOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES.

Dr. MCCLELLAN. Thank you. Mr. Chairman, I appreciate it. It is a real pleasure to be here with all of you this afternoon to discuss the savings that are available right now to Medicare beneficiaries through the Medicare prescription drug discount card and the transitional assistance program that goes along with it.

I especially want to thank this Committee, the Aging Committee, for its hard work on the Medicare Modernization Act, the law that made this immediate help for lower-income beneficiaries with financial help and discounts plus discounts for all beneficiaries possible and which we are working as hard as possible to bring the most savings to as many beneficiaries as we can right now, and that is what I want to talk about.

I expect that the moderator was held up in traffic going from the same event that I was. This morning, Jim Firman and I made some joint announcements about further steps that we are taking particularly focused on getting low-income beneficiaries to start saving. There are literally thousands of dollars in savings that they can get right now, and I am very pleased with Jim's work as the chairman of the Access to Benefits Coalition, which is a broad, nonpartisan group of organizations that have one goal in mind, which is to get the most help possible to as many Medicare beneficiaries as possible with their drug costs, and a key part of doing that is getting them informed about the facts of the Medicare drug discount card and getting them enrolled, and I am going to get back to that point in a minute, but Jim has been very busy today.

I also want to thank the CMS staff that has worked very hard over the last few months not only to implement this drug card pro-

gram on schedule but to continue to work to refine it, to improve it, to help it to be even more effective in providing discounts and getting assistance to more Medicare beneficiaries.

Well, it has been more than 3 months now, over 3 months ago, that Medicare beneficiaries began getting discounts on their prescription drugs through the drug card program as an important first step toward comprehensive drug coverage in Medicare, coverage that is way overdue. The voluntary drug card program is providing immediate relief now to seniors and people with disabilities who are covered under Medicare.

The discount cards have already enrolled and reduced prescription drug costs for over 4.4 million Medicare beneficiaries. That number is growing at about 10,000 new enrollees a day, and to put this in perspective, this is the fastest takeoff of any recent Federal health program, any recent voluntary program. There are now savings, for the first time, through Medicare. Medicare is bringing savings on prescription drugs to beneficiaries who do not have drug coverage. At CMS, we are pleased this afternoon to release a new set of studies on drug card savings based on our latest research. That research finds that seniors can save even more than it looked like they were saving in our earlier studies: 12 to 21 percent now on sets of brand name drugs, in comparison to the national retail average prices paid for by all Americans.

I want to be clear about this 12 to 21 percent number. That is in comparison to the average prices paid by all Americans, that includes most Americans who have long had drug coverage, and so, are able to get big discounts on their drug prices through the public insurance programs they are in like Medicaid or VA or the private insurance programs they are in. Medicare beneficiaries are now below average, significantly below average, 12 to 21 percent below average, when they use the drug cards.

You will hear more about the new CMS studies from Sharman Stephens on our staff, who has done a tremendous job for a long time at CMS and has been an integral part of making sure we are analyzing the drug card program as effectively as possible to help it work as effectively as possible. But no matter what methodology is used here, the savings of 12 to 21 percent on brand name drugs, the much larger savings on generic drugs, savings in comparison to retail prices that are offered, the findings are similar.

This goes as well for findings on Internet purchases of drugs. The drug cards are offering significantly lower prices, as much as 30 percent lower in some cases, on drugs compared to reputable Internet sites like Drugstore.com and Costco.com. In fact, Drugstore.com is now partnering with a number of Medicare drug discount cards to offer even lower prices to Medicare beneficiaries online through Drugstore.com.

So the price reductions are substantial. They are also present when you look at retail prices, where the usual retail prices for cash-paying customers can be significantly higher than the discounted prices that most people with insurance are able to obtain, and those comparisons show savings of typically 20 percent or more according to some of the other recent studies that you will hear about from the panel members.

It is very encouraging to us to see the consistent showing of significant savings on prescription drugs at local pharmacies, even larger savings on mail order drugs and very large savings on generic drugs available through this program. We have also set up some new ways to save, including an announcement last week. When you go to our Website, or when you call us at 1–800–Medicare, you can not only get information about how much you can exactly save on your prescription drugs that you are taking now, but if there are generic versions of the drugs available, we will tell you about them and tell you how much you can save on them, and again, generic savings can be on the order of 40, 50, 60 percent or more, and if there are drugs that work in a similar way to the drug you are taking for a cholesterol lowering drug or a drug for stomach acid or a nonsedating drug for your allergies, we will tell you about those alternatives as well to focus a discussion with your doctor where it can be most useful.

It is very hard to go into your physician, just ask about, gosh, how can I get savings on my prescriptions. It is much easier if you have got a piece of paper in front of you or the notes from your conversation with one of our customer service representatives saying that if you switch from Zocor to Mevacor, Lipitor, you could save $10, $20, $30 a month. That is an additional way to save that we are making possible in order to encourage more competition among prescription drugs to get the costs down.

So with these new studies that we are updating today, we are seeing clear and consistent savings that have persisted over the whole period of our analysis. I should highlight as well that the comparisons I mentioned, the 12 to 21 percent or more, is in comparison to the average prices that Americans paid in the first quarter of this year, so even going back 6 months plus to a time since when there have been some reports about list price increases for drugs, we are still seeing actually a little bit larger savings than in the past.

Our analyses now also extend to breadth of coverage. You know, there were a lot of concerns when this program started that there might be some bait and switch, and we said, "That we were going to be vigilant in watching out for that by keeping an eye on what is happening with prices." I just told you about some of the main features of our studies as well as some of the other studies that have been done.

But we are also looking at the drugs that have been covered. People were worried that some drugs that they were taking now might not end up continuing to get coverage on their drug card. Now, we are making available on our Website and when you call us at 1–800–Medicare some specific information on how broad the discounts are on each of the drug cards.

So with respect to that, I am pleased to tell you that all of the cards cover almost all of the top drugs used by seniors in this country. Many of the cards cover 100 out of the top 100 prescription drugs, and all of them cover at least 97 out of the top 100. That has been persistent over this program for the whole time it has been in existence.

We looked further at how well the cards do in covering all of the prescription medicines that are out there, all of the drugs marketed

in the United States, and you can get this information when you go to our Website or call us at 1–800–Medicare, and the vast majority of cards are covering, all of the cards are covering most of the drugs that are marketed in the United States, and most of the cards are covering 70, 80 percent or more of all prescription drugs in the U.S. A number of cards are over 90 percent of all of the prescription drugs marketed in the United States, so very broad coverage on the cards as well.

Now, as important as these real and persistent and broad savings are on the drug cards to all seniors and people with disabilities who are struggling with drug costs because they do not have good coverage, the drug card especially means a lot to people with limited means and no drug coverage. That is because it adds in $600 in assistance right on the card this year; it works very similarly to a debit card. When you use the card to fill your prescription, the cash that you have on the card will be taken off right then. You do not need to come up with the money yourself, and then, there is $600 more in assistance next year as well.

On top of that, after the $600 is used up, Medicare cards have worked with drug manufacturers to provide additional wraparound discounts on more than 200 brand name medications, including many of the top drugs, so 6 out of the top 10 prescriptions in the elderly are covered by these wraparound programs now, generally on multiple cards. The way the wraparounds work is after you use up that $600 credit, you get an extra large discount on your prescription.

You can typically get the prescription for close to if not only the cost of the dispensing fee. That is $15 or less for a prescription that might cost $80, $90, $100 otherwise. So if you add that all together, the discounts, the credit, the wraparound, this is thousands of dollars in help available right now with drug costs for the beneficiaries who need it the most. They do not have to choose anymore between paying for their drugs and paying for other basic necessities.

Because we know every dollar counts, the cards are free for low-income beneficiaries. This is why we at CMS have been trying to do as much outreach as possible to make sure lower-income beneficiaries especially are informed about the benefits of these cards, and that is why I am particularly pleased with the announcements that we have been able to undertake recently with the Access to Benefits Coalition; Jim, who was program stuck in the same traffic I was coming over from the National Press Club today, has been doing some tremendous work with more than 90 national organizations in the Access to Benefits Coalition that have a very simple nonpartisan goal, and that is to get the most help to lower-income beneficiaries with their drug costs as quickly as possible. Again, the drug card, the $600 annual credits, and the wraparound discounts are a key part of that effort, and I hope that Jim will have a chance to talk a little bit about some of the new steps that ABC is taking to make that happen.

This is very important, because the savings offered by the drug card are only available to people who are enrolled, and that is why we are working harder than ever to ensure that seniors, their families, care givers, all of them, have the information they need to

make informed decisions to select a card that can give them a lot of help right now.

If you are on Medicare, and you are struggling with drug costs, you should know that signing up is as simple as calling 1–800–Medicare with just a few pieces of information: your ZIP Code, your drugs and dosages that are found on the prescription bottles, and if you think you might qualify for the $600 credit and all of the wraparound assistance, your annual income.

We have staffed up at 1–800–Medicare. We have got over 3,000 trained customer service representatives who can walk you through the card choices. We will focus in on just a limited number of choices. We tend to talk about the top five, but if people want to hear about fewer than that or more than that, we can do that as well. The call to get all the information you need to find out about how to save takes less than 15 minutes. If you are interested, you can get a personalized brochure to take a closer look at the cards on paper before deciding which one to enroll in, but if you are ready to sign up when you call, our customer service representatives can tell you exactly what you need to do to enroll in a drug card over the phone.

Just today, with help from the Access to Benefits Coalition, we announced some new steps to make this even easier. We are incorporating information on all of the wraparound programs into the guidance that we give people when they call us up or when they visit our Website, and we are also making it easier to enroll in the transitional assistance over the phone or online as well.

It is not just us. Again, thanks to the work of the Access to Benefits Coalition, there is now another Website that people can use to get quick information and recommendations and help in getting signed up, getting enrolled and actually starting to get savings right now.

To ensure that seniors have all of the information that they need and that all seniors are educated about how they can start saving right away, we are engaging in more partnerships like this one with the Access to Benefits Coalition. We are partnering with community-based organizations, with States through their State health insurance assistance plans, with other Federal agencies to reach out to beneficiaries to make sure they get the facts about the discount cards and to make sure that they start saving.

Again, this is very important: no senior today should be choosing between drugs and other basic necessities. There is a lot of real help available right now, and we are working ourselves and with our many partners to get this help available as quickly and as easily as possible.

Now, I mentioned that we have got about 4.5 million people enrolled in the card program now. We are well over the 50 percent mark on enrollment, on expected enrollment, but I think we can do a lot better. That is why I think the step that we announced yesterday is so important, to add nearly 2 million lower income Americans to this program through automatic enrollment process.

These are lower income beneficiaries who are in limited Medicaid benefit programs that do not provide drug coverage. They are going to be getting a drug card in the mail next month. When they get the card, they can start using it beginning in November to get the

$600 credit. All they have to do is make one phone call and answer two questions. They can call us up at 1–800–Medicare. They can call the 800 number for the card sponsor. Just let us know that they do not have any other prescription drug coverage now and let us know that their income level is still below the level that gets them to qualify for the program. We think that is generally going to be the case, because we are targeting this automatic enrollment to beneficiaries who are already enrolled in Medicare savings programs, these limited Medicaid benefit programs, and then, they can start using the card right away.

So we are going to not only get these letters out in the next couple of weeks but with all of our partners around the country to make sure beneficiaries get the facts and know that they can get literally thousands of dollars in savings right away if they just start using this card. We hope, through this process as well, to reach many other lower-income beneficiaries who can get thousands of dollars in help right now as well.

The drug cards are an important step. They are providing real savings for beneficiaries right now, with millions more to come. They are also an important bridge to the new Medicare prescription drug benefit that will go into effect in January 2006. We expect that the experience from this card program is going to help get more discount card sponsors converted into drug benefit providers; it will also help the drug benefit plans do a better job of providing the best service, and it is certainly going to help us do the best job possible of informing people, working with public-private partnerships to help make sure they get the most benefits possible and to provide the most support and the most effective support we can to Medicare beneficiaries.

Through this process, beneficiaries are going to continue to get discounts on their drugs. With the drug benefit, the expectation is that the price, even lower negotiated prices may be possible. As both CBO and CMS have said in the independent analysis that is underlying our proposed regulations on the drug benefit, we think that the competitive approach to price negotiation that we are following is going to give the best possible prices, prices that are as good if not better than the Government could negotiate directly as well as more options in terms of making sure that people have access to the prescription drugs they need, not a one size fits all formulary.

So we are on the way to doing that, and we are going to use this experience to make sure that we get as many people enrolled as possible to take advantage of both of the benefits. I want to thank all of you again, especially the Chairman, for his leadership, and thank you all for the opportunity to talk today about the substantial savings that are available through the discount drug card program as we are taking an important step toward full prescription drug benefits in Medicare.

This has been too long in coming. We are working very quickly and as extensively as we can with outside partners to get as much help as possible to our beneficiaries, and even more is coming in the months ahead.

Thank you all very much. [Applause.]

[The prepared statement of Dr. McClellan follows:]

Statement (as prepared) of
Mark McClellan MD, PhD
Senate Aging Committee
Medicare-Approved Prescription Drug Discount Card Forum
September 23, 2004

Chairman Craig, Senator Breaux, {distinguished Committee members}, thank you for inviting me here today to discuss the substantial savings available to Medicare beneficiaries through the Medicare Prescription Drug Discount Card and the Transitional Assistance Program. I especially want to thank this committee for its hard work on the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and your support for CMS as we work to implement this important new law as effectively as possible.

Over three months ago Medicare beneficiaries began receiving discounts on their prescriptions through the Medicare-approved drug card program as an important first step toward comprehensive Medicare prescription drug coverage. This voluntary drug card program is providing immediate relief to seniors and disabled people covered under Medicare. I am happy to report that the discount drug cards have successfully reduced the cost of prescription drugs for over 4.4 million Medicare beneficiaries and that number is growing by about 10,000 new enrollees a day.

Big Savings for Medicare Beneficiaries
For the first time, Medicare beneficiaries without drug coverage are realizing big savings on their prescription drugs. We at CMS are pleased that our latest research has found that seniors could save 12 to 21 percent now on sets of brand name drugs compared to national average retail pharmacy prices and much more through the use of generics and mail order pharmacies. And our latest study found that beneficiaries can save 10 to 75 percent over national average retail pharmacy prices for individual drugs often used to treat some common health conditions. You'll hear more about this and our other CMS studies from Sharman Stephens of my staff and about external studies from several independent groups shortly. It's exciting to note that all of the research has consistently shown great savings for beneficiaries. No matter which methodology or mix of drugs is used – brand versus generic, baskets versus individual drugs, weighted by volume sales or not – all methodologies yield very similar findings. These price reductions are on the drugs that beneficiaries use commonly, including many drugs not included in the formularies of government-run drug plans.

Because of the cards, for the first time, price transparency is part of the prescription drug market. And, the new Medicare-approved drug discount cards offer Medicare beneficiaries the ability – for the first time – to band together and comparison-shop to meet their drug needs. Purchasing power combined with competitive pressures and the public release of drug prices has driven prices down, leading to better deals, volume discounts, and savings for our seniors.

As important as those savings are to seniors, the discount drug card has even more to offer those with limited means and no drug coverage. This includes $600 in cash assistance right on the card – it works similar to a debit card – and $600 more in assistance next year. On top of that, after the $600 is used, Medicare cards have worked with drug manufacturers to provide additional wraparound discounts. This is thousands of dollars in help available right now with drug costs – patients don't have to choose anymore between paying for their drugs and paying for other basic necessities. And because we know that every dollar counts, the cards are free for low-income beneficiaries. We at CMS, along with the 85 national organizations in the Access to Benefit Coalition urge every low-income beneficiary who is eligible for a Medicare drug discount card with the $600 annual credit to take advantage of these savings now.

Simple Steps To Start Saving

The great savings offered by the drug cards, however, are only available to those who choose them. That's why we are working hard to ensure seniors, their families, and care-takers have all the information they need to make an informed decision and select the card that works best for them. Despite inaccurate information to the contrary, if you're on Medicare and you're struggling with drug costs, you should know that signing up is as simple as calling 1-800-MEDICARE with three pieces of information - their zip code, their drugs and dosages found on their prescription bottles, and, if they think they might qualify for the $600 credit, their annual income. We have 3,000 trained customer service representatives who can walk through the top five drug card options in less than 15 minutes to find the card that's best for each beneficiary. If you are interested, you can get a personalized brochure so you can take a close look before deciding to enroll. But if you are ready to sign up when you call, our customer service representatives can tell you exactly what you need to do to enroll over the phone.

Last week CMS added the "Lower Cost Rx Comparison Tool" to its website to help seniors comparison shop and choose lower-cost drugs, similar to those they are currently using. Medicare beneficiaries interested in using the new comparison tool can simply go to the "prescription drug and other assistance program" section of www.medicare.gov or call 1-800-MEDICARE and provide the medications they are currently taking. A customized report will be generated for each of their medications, including less expensive versions of the same drug and brand name and/or generic versions of similar but less expensive drugs that are available to treat the same condition. The website also offers beneficiaries the opportunity to research the prices and cards accepted by their local pharmacies.

To ensure seniors have all the information they need to make an informed choice, we are partnering with community-based organizations, States, and other Federal agencies to reach out to beneficiaries to ensure they know about the savings available through the discount cards. Beneficiaries could also ask their pharmacists for assistance, as they are the most familiar with individual situations and needs.

Enrollment Steadily Increases

As of September 16, more than 4.4 million beneficiaries had enrolled in a card program, well over 60 percent of the 7.3 million seniors who CMS estimated would sign up for the card by December of 2004. More than 1.1 million of those beneficiaries are receiving the $600 low-income credit. Approximately 2.4 million beneficiaries were automatically enrolled in a card by their health plans and nearly 350,000 were auto-enrolled through their state pharmacy assistance program, with an additional 13,000 being sent pre-filled applications by their state pharmacy assistance program.

And nearly two million low-income Americans on Medicare will soon be automatically eligible for prescription discounts through the Medicare Drug Discount card. These Medicare beneficiaries will receive a drug discount card in the mail next month, which they can begin to use immediately to get savings at pharmacies. Letters will go to people who receive state help to pay Medicare premiums in what are known as Medicare Savings Programs. These beneficiaries meet the income tests to make them eligible for the $600 credit.

A Bridge to the Drug Benefit

The drug cards will serve as an important bridge to the new Medicare prescription drug benefit that will go into effect January 1, 2006. CMS expects that a number of drug discount card sponsors will want to provide those new benefits and will therefore offer the best service they can while participating in the drug discount card program. We intend to make sure the drug benefit builds on the new tools we are giving seniors now as part of the drug card. For example we'll keep making available information on prices and alternative lower cost drugs so beneficiaries can find the best fit for their needs. And the drug plans will continue to negotiate lower prices by using the buying power of beneficiaries in the plans for the drugs and formularies that seniors want.

Thank you again for the opportunity to talk today about the substantial savings available to seniors through discount drug cards, an important transition toward Medicare's prescription drug benefit. We recognize, as did the President, the importance of the discount cards and the low-income subsidy to Medicare beneficiaries, who, for too long, have gone without outpatient prescription drug coverage.

Simple Steps to Start Saving on Drugs With a Medicare-Approved Discount Drug Card

1. Know your:
    - Zip code
    - Drugs and doses
    - Monthly income
2. Call 1-800-MEDICARE
3. A customer service representative will help you choose the card that's best for you!

The CHAIRMAN. Well, Mark, thank you very much.

Folks, do the math. Our targeted group is about 7.3 million. We are at 4.4 million now. The program that Jim and Mark have just announced today will add about 1.8 or 2 million in a 3-month period of time and more. That is pretty good business, and we applaud you for it and appreciate it.

I do appreciate, Mark, you joining us and sharing those numbers today. It is important that we keep track of this program as it goes along, get the real numbers and understand them and the kind of cooperative effort that is well underway. You and your staff, I think, deserve a great deal of credit for handling a huge task of implementing this new Medicare program in the way that you have.

It is probably not much of an exaggeration to say that drafting the original bill was a picnic compared to the implementation of the details, and I will tell you how we struggled in the picnic trying to get a bill that we felt would work and would respond to the needs of our seniors.

I guess I can understand, Mark, why you get the award indispensable person from the Alliance for Aging Research that you got this past week. That is greatly appreciated, I am sure.

Next, we will turn the proceedings over to Jim Firman. Jim has arrived, after having been, I understand, caught in a motorcade. He will be the moderator of the panel. Jim, as you now know, is president of the National Council on the Aging as well as leader of the recently founded Access to Benefits Coalition. Jim's ABC Coalition has successfully brought together dozens of organizations across the country and is doing tremendous work in reaching out to seniors and helping them gain access to the benefits of the new Medicare law.

So, Jim, we thank you very much for being here on what we now understand has been a busy day for you. We look forward to your moderating and introducing the panelists. Panelists all, thank you very much for being with us this afternoon and sharing your information and the research work you have done.

Thank you.

STATEMENT OF JIM FIRMAN, PRESIDENT, NATIONAL COUNCIL ON THE AGING, CHAIR, ACCESS TO BENEFITS COALITION

Mr. FIRMAN. Thank you very much. Thank you, Senator Craig, Dr. McClellan. [Pause.]

Thank you very much. My name is Jim Firman. I have the pleasure of chairing the Access to Benefits Coalition, which is a coalition of more than 90 national, nonprofit organizations and 52 State and regional coalitions, all who have come together for only one purpose: to make sure that low-income Medicare beneficiaries can get the best possible coverage and savings for prescription drugs.

We are nonpartisan. We are only about finding people and helping them get the coverage they need, whether it is State programs, Medicare cards, the best possible Medicare cards, company patient assistance programs, veterans' benefits, Medicaid. We do not care. We want to find the best combination to work for people.

We are delighted to be here today, because we have been working closely with Administrator McClellan to find ways to get as

many people as possible into the benefits. We are very pleased to be able to be part of the announcement yesterday that CMS is going to auto-enroll 1.8 million low-income people in the benefit. That is a great step forward. Today, we were announcing the new tools for consumers, a new Website called Accesstobenefits.org put together by the coalition, designed to help people quickly and easily figure out the best combination of programs and then enroll in those benefits.

It takes a somewhat different approach than Medicare.gov, but they are both wonderful Websites full of wonderful information, and we encourage people to use both of those or either of them, whatever works. You will find sometimes, we approach a little differently, but pretty much, we come to the same kinds of answers, that there are more benefits out there than people realize, and the need is for people to sign up for them now.

But as we have done our research, and we have done extensive research in focus groups and talking to older people, what we find is that many older people and people with disabilities on Medicare, particularly those with lower incomes are skeptical. They have heard a lot of things. They are not sure how significant the savings really are. They do not know whether they will qualify for them, even though we are looking at people who in many cases we know are eligible. They do not think that they will be able to access those benefits.

That is why today is so important, because I am delighted to have the opportunity to chair this panel, where we can get some of the facts, and we can find out what is really going on, what are the savings, how many of them, because this is very important, I think, for consumers to understand, for the public to understand as well.

So let us get on to the real substance of this panel, and let us hear from the folks who have done the research and who can tell us their findings. Our first presenter—the way this is going to work is we are going to hear four presentations, about 5 minutes each, and then, we are going to open it up into a discussion and ask questions. I am going to ask some questions. You on the floor will have an opportunity to write down and to pass questions up as well. But the goal is to help educate all of us as to what is really going on in terms of costs and prices.

So the first speaker will be Sharman Stephens, who is the director of planning and policy analysis in the Office of Research and Development Information at the Center for Medicare and Medicaid Services at HHS. She has been there since 1996, and before that, she was with the Office of the Assistant Secretary for Planning and Evaluation at HHS. She is a graduate of the Duke University School of Nursing and had received her master's in public health from the University of North Carolina.

STATEMENT OF SHARMAN STEPHENS, DIRECTOR, PLANNING AND POLICY ANALYSIS, OFFICE OF RESEARCH AND DEVELOPMENT INFORMATION, CENTER FOR MEDICARE AND MEDICAID SERVICES

Ms. STEPHENS. Thank you.

Good afternoon. I want to thank you for inviting me to discuss the analyses we have conducted regarding the level of savings available to Medicare beneficiaries enrolling in Medicare-approved drug discount cards. My remarks this afternoon will focus on a series of CMS studies that have examined the level of savings available to Medicare beneficiaries through these cards.

We have examined prices offered by the Medicare approved cards from a variety of angles. In the initial weeks of program implementation, we found that overall, and as we are showing on that first chart over there, for non-low-income beneficiaries, absent the $600 in transitional assistance, savings of 11 to 18 percent were possible over national average retail pharmacy prices for the illustrative baskets of commonly used drugs we examined.

We reexamined the prices posted on the Medicare comparison Website last week for the same sets of commonly used drugs examined previously. As shown on the chart, we found that savings are now ranging from almost 12 percent to over 21 percent for the baskets of drugs we examined. As Dr. McClellan pointed out, our point of comparison in these analyses is to national average retail prices, which include both the higher prices paid by people without insurance, normally, we call them the cash-paying customer, and the lower prices paid by people with private and public insurance, and most people, actually, have coverage. But as a result, we would actually expect that beneficiaries' savings would be larger for those who are currently paying cash prices at retail pharmacies.

As you can see, on the right side of the chart, because of the annual $600 in transitional assistance, the savings for low-income beneficiaries are even greater. Using data from last week and estimating for the 4-month period from September to December of 2004, we found that when the discounts and the $600 in transitional assistance are considered, low-income beneficiaries during this period can save from nearly 44 to 92 percent, compared to national average retail prices.

These savings can be substantially greater for some beneficiaries when the special very low pricing arrangements on over 200 drugs now being offered by several brand name pharmaceutical manufacturers, in coordination with the Medicare discount card programs, are considered. Forty-six out of these 200 drugs are actually among the top 200 drugs used by the 65 and over population.

It is also important to note, and I am going to be moving over to the next chart here, that generic drugs offer all beneficiaries a chance to save even more on their drug costs. As shown in the second chart, in a June study on generic drugs, we found that those who can switch to generic drugs can save 46 to 92 percent over the cost of brand-name drugs we examined. We also found that those beneficiaries already taking generic drugs could save 37 to 65 percent over national average retail pharmacy prices by enrolling in a Medicare-approved discount drug card.

As a quick update, based on prices posted last week, we saw commonly used generic drugs with savings of 45 to almost 75 percent. That is shown on the right side of the second chart.

Because some beneficiaries may choose to get their prescriptions through mail order, we have also examined the mail order market. Our analyses found that Medicare-approved drug card prices for mail order consistently beat the prices offered by popular mail order pharmacies. For example, using 10 commonly used drugs, we found that the best Medicare-approved drug cards had prices on these drugs ranging from 5 to 33 percent lower than drugstore.com and 11 to 34 percent lower than Costco.com.

On the third chart, the top red line is Costco.com, the second line, which is blue, is Drugstore.com, and the bottom line in green is Medicare. This third chart illustrates the savings in dollars for a few commonly used drugs, in this case, Celebrex, Prevacid, Norvasc, and Zocor.

Often, the retail pharmacy prices of the Medicare cards, are actually higher than mail order, but we were finding that the Medicare cards with the best prices beat mail order prices many, many times for these popular Internet service pharmacies.

Our research has also examined the prices from the perspective of medicines used to treat common health conditions such as diabetes, hypertension, heart disease, and osteoporosis, that are common in the Medicare population. Again, updating a prior study, using prices posted on the Web last week, we found that beneficiaries with nine common chronic conditions can save anywhere from about 10 to 75 percent over national average retail pharmacy prices for drugs often used to treat these ailments. The higher percentage savings being associated on a percent terms on the generic drugs, but we were also finding discounts of more than 20 percent on brand name drugs.

Our final chart shows dollar savings for four common conditions. For example, for beneficiaries using medications to treat high cholesterol, we are seeing savings per monthly prescription of $14 to $42. Even at the fifth card down the list, we saw per prescription savings of $10 to $42 per prescription.

We have also recently examined drug card program coverage of the top 100 drugs, and Dr. McClellan made reference to this. It is comprehensive coverage, and the coverage has been stable between when the program started in June and September.

As you can see, our analyses show that the discount drug cards offer substantial, reliable savings to Medicare beneficiaries and particularly those low-income beneficiaries who are eligible for the annual $600 in transitional assistance and the special manufacturer wraparound programs.

I want to thank you for the opportunity to participate in today's forum, and I would be happy to answer any questions about our analyses.

[The prepared statement of Ms. Stephens follows:]

Statement of
Sharman Stephens, M.P.H.
Senate Aging Committee
Drug Card Forum
September 23, 2004

Good afternoon thank you for inviting me to discuss the analyses we have conducted regarding the level of savings available to Medicare beneficiaries enrolling in Medicare-approved drug discount cards.

Savings of 12 to 21 Percent on Commonly Used Drugs
My remarks this afternoon will focus on a series of CMS studies that have examined the level of savings available to Medicare beneficiaries through these cards. We have examined prices offered by the Medicare-approved cards from a variety of angles. In the initial weeks of program implementation we found that overall, for non-low-income beneficiaries, absent the $600 in transitional assistance, savings of 11 to 18 percent were possible over national average retail pharmacy prices for the illustrative baskets of commonly used drugs we examined. We re-examined the prices posted on the Medicare comparison website last week for the same sets of commonly used drugs examined previously. As shown on the chart, we found that savings are now ranging from almost 12 percent to over 21 percent. Our point of comparison in these analyses is to the national average retail prices, which include both the higher prices paid by people without insurance and the lower prices paid by people with private and public insurance. As a result, we would expect beneficiary savings to be larger for those who are currently paying cash prices at retail pharmacies.

Savings of 44 to 92 Percent on Commonly Used Drugs With $600 Assistance
As you can see on the right side of the chart, because of the annual $600 in transitional assistance, the savings for low-income beneficiaries are even greater. Using data from last week and estimating for the four-month period from September through December 2004 we found that when the discounts and the $600 in transitional assistance are considered, low-income beneficiaries during this period can save from nearly 44 to 92 percent compared to national average retail prices. These savings can be substantially greater for some beneficiaries when the special very low pricing arrangements on over 200 drugs now being offered by several brand-name pharmaceutical manufacturers in coordination with the Medicare discount card programs are considered. Forty-six of these drugs are among the top 200 drugs used by the 65 and over population.

Greater Savings With Generic Drugs
It is also important to note that generic drugs offer all beneficiaries a chance to save even more on their drug costs. As shown on the second chart, in a June study on generic drugs we found that those who can switch to generic drugs can save 46 to 92 percent over the cost of brand name drugs we examined. We also found that those beneficiaries already taking generic drugs could save 37 to 65 percent over national average retail pharmacy prices by enrolling in a Medicare-approved discount drug card. Again as a quick update,

based on prices posted last week, we saw commonly used generic drugs with savings of 45 to almost 75 percent. This is shown on the right side of the chart.

Medicare-Approved Drug Card Prices Beat Popular Mail Order Prices
Because some beneficiaries may choose to get their prescriptions through mail order we have also examined the mail order market. Our analyses found that Medicare-approved drug card prices for mail order consistently beat the prices offered by popular mail order pharmacies. For example, using 10 commonly used drugs we found that the best Medicare-approved drug cards had prices on these drugs ranging from 5 to 33 percent lower than drugstore.com and 11 to 34 percent lower than Costco.com. This third chart illustrates the savings in dollars for a few commonly used drugs, Celebrex, Prevacid, Norvasc, and Zocor. In addition, often, the retail pharmacy prices of the Medicare cards with the best prices beat the mail order prices of popular Internet service pharmacies.

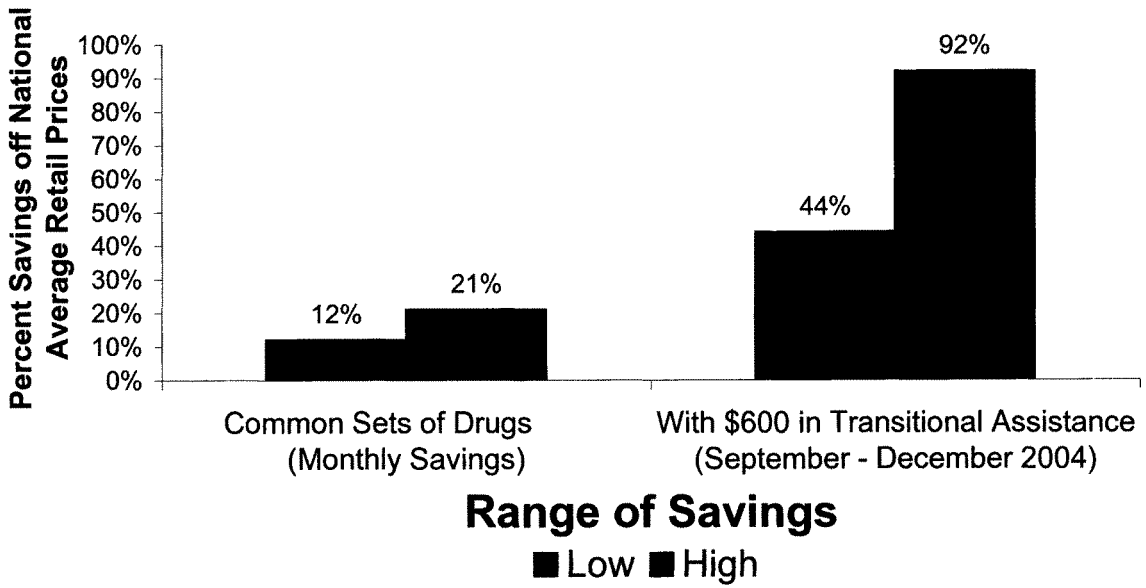
Beneficiaries with Common Health Conditions Save 10 to 75 Percent
Our research has also examined the prices from the perspective of medicines used to treat common health conditions, such as diabetes, hypertension, heart disease, and osteoporosis. Again updating a prior study, using prices posted on the web last week, we found that beneficiaries with nine common chronic conditions can save anywhere from about 10 to 75 percent over national average retail pharmacy prices for drugs often used to treat these ailments, including finding discounts of more than 20 percent on some brand name drugs. Our final chart shows savings for four common conditions. For example, for beneficiaries using medications to treat high cholesterol we are seeing savings per monthly prescription of $14 to $42. Even at the 5th card down the list we saw per prescription savings of $10 - $42.

Medicare-Approved Cards Offer Comprehensive and Stable Coverage
We have also recently examined drug card program coverage of the top 100 drugs. It is comprehensive coverage and this coverage has been stable between June and September.

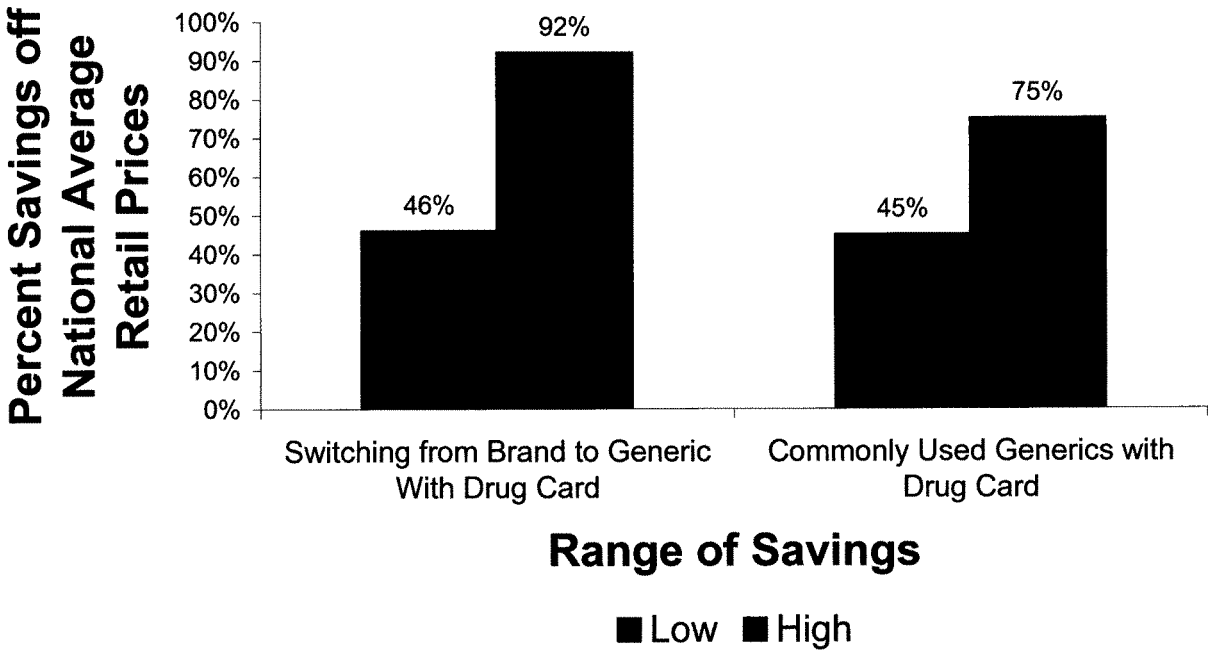
Medicare-Approved Cards Offer Reliable Savings, Particularly for Those With Low Incomes
As you can see, our analyses show that the discount drug cards offer substantial reliable savings to Medicare beneficiaries, and particularly those with low incomes who are eligible for the annual $600 in transitional assistance and special manufacturer programs.

Thank you for the opportunity to participate in today's forum. I would be happy to answer any questions about our analyses.

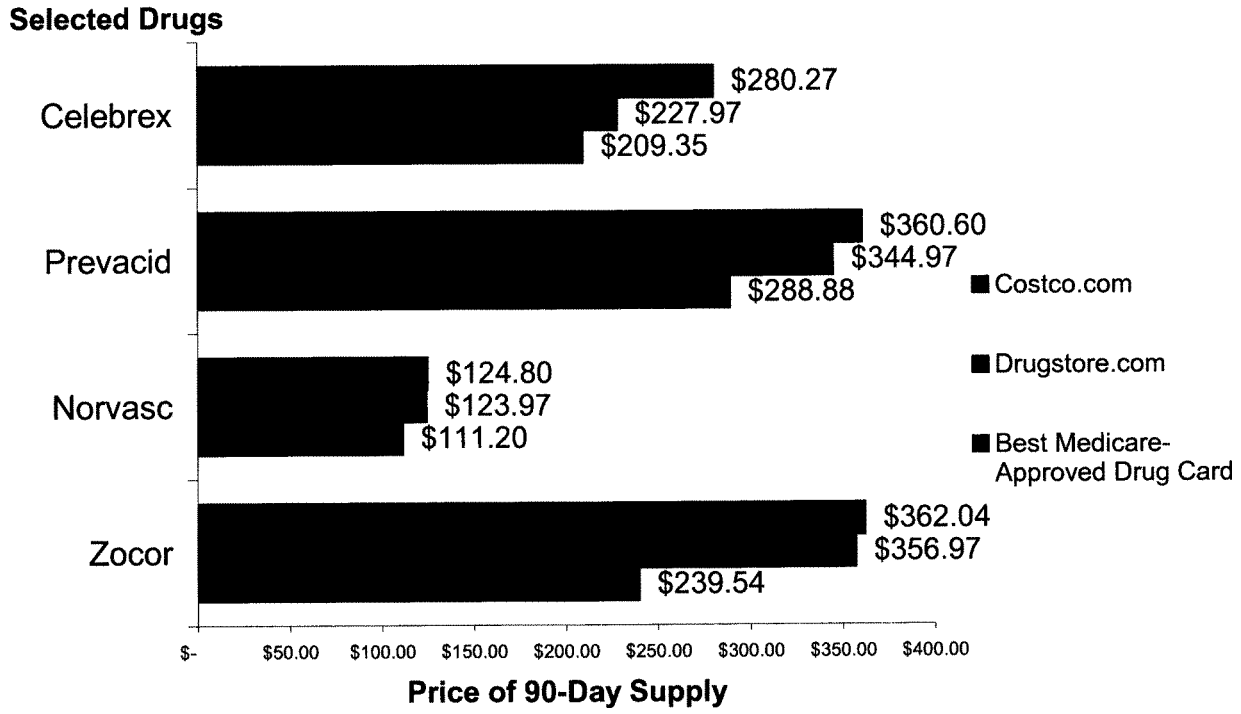
Range of Drug Card Savings (%) Off National Average Retail Prices: Illustrative Beneficiaries



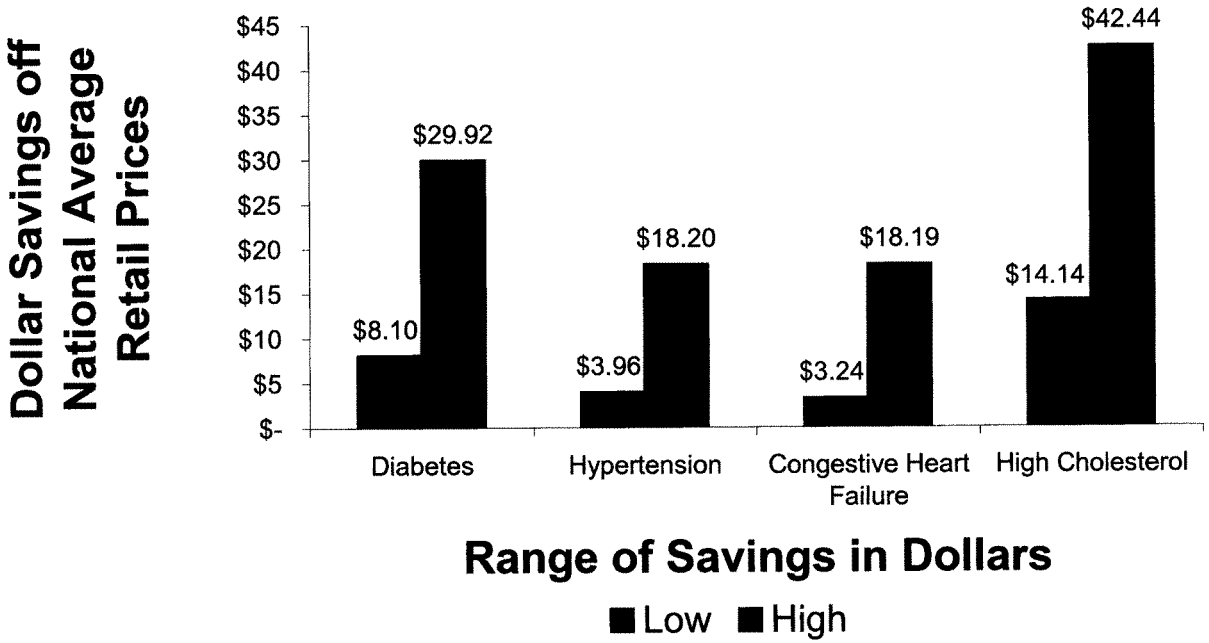
Range of Drug Card Savings (%) With Generic Drugs



Medicare-Approved Cards Mail Order Prices Compared to Internet Pharmacy Prices



Drug Card Savings ($) Per Monthly Prescription for Common Conditions



CMS Studies Confirm Significant Savings Through Medicare-Approved Drug Discount Cards

Updated September 23, 2004

Overview

The Centers for Medicare & Medicaid Services (CMS) has conducted several studies analyzing the discounted prices available through Medicare-approved drug discount cards over the past several months.[1] These studies have been updated to reflect September pricing information on www.medicare.gov. The studies continue to find that significant savings are available through Medicare-approved drug discount cards for beneficiaries purchasing drugs at retail pharmacies or mail order pharmacies. In addition, low-income beneficiaries can take advantage of very large savings when the discounts, the annual $600 in transitional assistance, and large "wrap-around" programs from many drug manufacturers are taken into account. The attached tables reflect the updated analyses. Except as otherwise noted, the updated CMS analyses reflect drug card prices on www.medicare.gov for the week of September 13, 2004.

Updated CMS Findings

- **Overall savings**. Beneficiaries can obtain discounted prices that are about 12 to 21 percent less than the national average prices actually paid by all Americans (including the higher prices paid by cash paying customers and the lower prices paid by people with public or private insurance) for commonly used brand-name drugs at retail pharmacies. These savings are 1 to 3 percentage points higher than the savings highlighted in our previous analyses conducted during the initial weeks of the program.

- **Savings compared to mail order pharmacies**. Beneficiaries enrolling in Medicare-approved discount cards can also obtain significant savings on prescription drugs purchased through mail order pharmacies. For 10 commonly used drugs we examined, our analysis found the best Medicare-approved drug discount card offered prices at least 5 to 33 percent lower compared to Drugstore.com and 11 to 34 percent lower compared to Costco.com. Further, the Medicare-approved cards with the best retail prices even beat Internet mail order prices most of the time.

- **Special savings for low-income beneficiaries**. For the 4-month period of September through December 2004, we estimate that low-income beneficiaries can save much more—nearly 44 to 92 percent over national average retail pharmacy prices—when using the Medicare-approved drug discount card with the best prices and the $600 transitional assistance. Once the $600 credit is exhausted, many low-income beneficiaries can get significant additional savings from the special discounts offered by several manufacturers in conjunction with Medicare drug discount cards.

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[1] CMS analyses related to Medicare-approved drug card pricing can be found at http://www.cms.hhs.gov/medicarereform/drugcard/drugcardreports.asp

- **Savings on drugs used to treat common health conditions**. The updated CMS analysis on drugs used to treat common health conditions shows that savings of about 10 to 75 percent over average retail prices (depending on the individual drug) are available by enrolling in a Medicare-approved drug discount card, with some of the greater savings available on generic drugs.

- **Savings on generics**. Beneficiaries who currently use generic drugs can obtain large savings by using a Medicare drug discount card, saving 45 to 75 percent below typical prices paid by Americans for commonly used generic drugs. Beneficiaries currently using brand name drugs who are able to switch to generics can achieve even greater savings of 46 to 92 percent.

Savings on Commonly Used Brand-Name Drugs at Retail Pharmacies (Table 1)
Many Medicare beneficiaries prefer to buy drugs from retail pharmacies because they offer service in-person. CMS updated its studies released in the early weeks of the program that examined the prices of brand-name drugs commonly used by beneficiaries to determine discounts available through Medicare-approved drug discount cards at retail pharmacies across the country. The updated analysis found that seniors could save 12 to over 21 percent on baskets of commonly used drugs compared to national average retail pharmacy prices actually paid by all Americans (including the higher prices paid by cash paying customers and the lower prices paid by people with public or private insurance). Before the Medicare-approved prescription drug card program was implemented, beneficiaries without drug coverage paid among the highest prices in the nation for their prescriptions. Savings of 12 to 21 percent over national retail pharmacy prices means significant savings for Medicare beneficiaries.

The national average retail pharmacy prices used in this study—and referred to throughout this document—represent the total price paid to the pharmacy, regardless of whether the person has insurance. The average is generally lower than the "cash" prices paid by Medicare beneficiaries without drug coverage. It includes both the relatively high retail cash prices paid by people without insurance and the lower negotiated prices paid by people with insurance. Savings would be higher if cash retail prices were compared directly to Medicare-approved drug discount card prices found on Medicare's Price Compare Website.

Savings Compared to Popular Online/Mail-Order Pharmacies (Tables 2a and 2b)
Some beneficiaries use mail order for some or all of their prescriptions. Beneficiaries enrolled in a Medicare-approved discount card can get large savings on their prescription drugs through mail order options offered by many participating card sponsors. There had been efforts to discredit the savings offered by Medicare-approved drug discount cards by comparing the retail prices offered through the Medicare-approved cards to mail order prices offered through popular mail order pharmacies.[2] In order to assess the validity of

[2] *Medicare Drug Card Prices Remain High*. United States House of Representatives Committee on Government Reform—Minority Staff. June 2004. This study contained data that could not be replicated

such claims, we conducted analyses comparing the mail order prices offered by Medicare-approved cards to other mail order prices. We also compared the retail prices offered by Medicare-approved cards to mail order prices. Our results indicate that the mail order programs of the best Medicare-approved cards beat the prices offered by popular Internet pharmacies. And, in many cases, the retail prices of Medicare-approved cards also beat popular Internet mail order prices.

Using data from the week of September 13th again CMS looked at savings available to beneficiaries when the drug card was used at a mail-order pharmacy. The study compared mail order prices from Medicare.gov to prices found at Drugstore.com and Costco.com. CMS consistently finds that the Medicare-approved drug discount cards offer significant savings for 10 commonly used drugs when compared to these web-based services. Our analysis found the best Medicare-approved drug discount cards ranged from at least 5 to 33 percent compared to Drugstore.com and 11 to 34 percent lower compared to Costco.com.[3] Clearly, seniors can see significant savings by purchasing drugs at mail-order pharmacies available through their card program.

Savings and Transitional Assistance for Low-Income Beneficiaries (Tables 3a and 3b)
A June 2004 study examined how low-income beneficiaries (below 135 percent of the Federal Poverty Level, or FPL) are being helped by Medicare-approved drug discount cards, including the $600 in transitional assistance. Recently updated analysis on the savings available to low-income beneficiaries indicates that beneficiaries eligible for transitional assistance who pick the card with the lowest price can save about 44 to 92 percent off of national average retail prices over a four-month period (September–December 2004) on brand name drugs purchased at retail pharmacies. Those who pick a card that is 5th down the list also save a significant amount—42 to 91 percent. Given the availability of discounts and $600 in transitional assistance, lower income Medicare beneficiaries are better off enrolling in any number of Medicare-approved drug discount cards than not enrolling at all.

Some low-income beneficiaries can save even more by taking advantage of special pricing arrangements many brand name manufacturers have with card sponsors once a beneficiary's $600 is spent. Drugs may be available at no cost (other than a pharmacy dispensing fee), or, for example, a low, flat co-pay (e.g., $12-$15) after the $600 credit is exhausted. The benefits for a low-income individual of enrolling in a Medicare-approved drug card are clear and substantial.

Savings for Beneficiaries with Common Conditions (Table 4)
Ninety-one percent of Medicare beneficiaries fill at least one prescription each year. Many of these beneficiaries take drugs to treat conditions such as diabetes, depression, or hypertension. Given the prevalence of chronic conditions and the savings available

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by CMS. It also included an inaccurate comparison between retail and mail-order prices: mail-order prices are generally lower than retail due to lower fixed costs, 90-day supplies, and other factors.

[3] Total savings are actually greater because the Internet sites did not include membership fees and shipping in the prices indicated at the websites. The Medicare-approved drug card mail order prices include shipping costs.

through the discount program, many seniors and persons with disabilities can get significant savings by signing up for a card. CMS updated its June 29, 2004 study that examined the savings available to beneficiaries on 23 drugs indicated for the treatment of nine very common conditions. Depending on the individual drug, our updated analysis indicates that beneficiaries being treated for diabetes can save about 10 to 56 percent with the best-price card, and even 8 to 49 percent with the card fifth down the list. Those beneficiaries being treated for congestive heart failure can save 25 to nearly 74 percent with the best card and 16 to almost 70 percent with the card fifth down the list. The drug card may be valuable to beneficiaries with chronic conditions, particularly since most beneficiaries with chronic conditions frequently take more than one drug to treat their conditions.

Generic Substitution Means More Savings (Table 4)
A previous CMS study indicated that beneficiaries could save by substituting generic drugs for brand-name drugs when they are available. Generic drugs are chemically equivalent, work in the same way, and are regulated by the FDA in the same way as their brand name counterparts— but they cost much less. That study indicated that beneficiaries who switch to generics can save between 46 and 92 percent off the prices of branded drugs. The savings come only in part from the fact that generic drugs are generally much less expensive than brand-name drugs. In addition, the discount cards provide even larger discounts for generic drugs. For example, updated data from the week of September 13, 2004 indicates that for several commonly used generic drugs the best Medicare-approved drug discount cards are offering prices that are 45 to 75 percent less than the national average retail pharmacy price actually paid by Americans for these generic drugs. Generic drugs are a safe and inexpensive alternative for beneficiaries who can use them. For low-income beneficiaries, switching to generics stretches the $600 transitional assistance further.

Other Drug Card Studies
Others have found similar results of savings from the Medicare-approved drug discount card program. Henry J. Kaiser Family Foundation released a report on July 28, 2004 (Medicare Drug Discount Cards: A Work in Progress, July 28, 2004), indicating that all seven Medicare-approved discount drug card programs they examined "had prices that were significantly less than those reported by the Maryland Attorney General as typical retail prices." Further, the report indicates that beneficiaries could save 8 to 61 percent over these typical retail prices for the 10 drugs they studied. Another report, prepared by The Lewin Group for the Healthcare Leadership Council and released on August 12, 2004, indicated savings, on average, of over 20 percent. Lewin found that nationally, the best Medicare-approved drug discount cards offer savings of almost $10 per prescription, representing a discount of more than 20 percent overall. More than half of the drug discount cards yield savings of over $8.48 (over 17 percent) per prescription. Another study finding was that, across the 150 drugs most commonly prescribed to seniors, the best available price from any card sponsor represents an average savings per prescription of over $17 (23 percent). A report published by the American Enterprise Institute for Public Policy Research (Private Discounts, Public Subsidies: How the

September 23, 2004

Medicare Prescription Drug Discount Card Really Works, 2004) also indicates that real savings are available for beneficiaries, particularly low-income beneficiaries.

TABLE 1 - PRICE COMPARISON RETAIL PHARMACIES -- NON-LOW-INCOME

Illustrative Medicare Beneficiary/Residence	Conditions	Drugs	Dosing	National Retail Average Monthly Price[1]	Medicare Drug Discount Card Monthly Price[2]	% Savings Drug Card vs. Average Retail Market	Monthly Dollar Savings
Beneficiary #1							
National	**Market Basket Total**			**$363.60**			
Pittsburgh, PA 15122	**Market Basket Total**				**$286.30**	**-21.3%**	**$77.30**
Portland, OR 97202	**Market Basket Total**				**$284.77**	**-21.7%**	**$78.83**
	Osteoarthritis	Celebrex	200 mg per day				
	Hypercholesterolemia	Zocor	40 mg per day				
	Depression	Paxil	20 mg per day				
	Hypertension	Norvasc	5 mg per day				
Beneficiary #2							
National	**Market Basket Total**			**$130.50**			
Louisville, KY 40205	**Market Basket Total**				**$114.92**	**-11.9%**	**$15.58**
Orange County, CA 90623	**Market Basket Total**				**$114.92**	**-11.9%**	**$15.58**
	Hypertension	Prinivil	20 mg per day				
	Diabetes	Glucophage	850 mg twice per day				
	Congestive Heart Failure	Lasix	40 mg per day				
Beneficiary #3							
National	**Market Basket Total**			**$319.20**			
Boston, MA 02762-Bristol	**Market Basket Total**				**$264.90**	**-17.0%**	**$54.30**
Houston, TX 77204	**Market Basket Total**				**$265.08**	**-17.0%**	**$54.12**
	Hypertension/mild congestive heart failure	Lisinopril	20 mg per day				
	Coronary artery disease/congestive heart failure	Toprol XL	200 mg per day				
	Hypercholesterolemia	Lipitor	40 mg per day				
	Acid Reflux	Aciphex	20 mg per day				
Beneficiary #4							
National	**Market Basket Total**			**$481.50**			
Boise, ID 83714	**Market Basket Total**				**$422.77**	**-12.2%**	**$58.73**
Greensboro, NC 27410	**Market Basket Total**				**$422.77**	**-12.2%**	**$58.73**
	Schizophrenia	Zyprexa	10 mg per day				
	Hypercholesterolemia	Lipitor	40 mg per day				
	Depression	Zoloft	50 mg per day				
Beneficiary #5							
National	**Market Basket Total**			**$187.50**			
Greenville, MS 38731	**Market Basket Total**				**$162.99**	**-13.1%**	**$24.51**
Arlington, VA 22202	**Market Basket Total**				**$155.01**	**-17.3%**	**$32.49**
	Anticoagulant	Coumadin	2.5 mg per day				
	Osteoarthritis	Vioxx	25 mg per day				
	Osteoporosis	Fosamax	70 mg per week				
Beneficiary #6							
National	**Market Basket Total**			**$384.30**			
Clearwater, FL 33767	**Market Basket Total**				**$321.67**	**-16.3%**	**$62.63**
Cleveland, OH 44106	**Market Basket Total**				**$321.67**	**-16.3%**	**$62.63**
	Diabetes	Glucophage	850 mg twice per day				
	Diabetes	Actos	30 mg per day				
	Hypercholesterolemia	Pravachol	40 mg per day				

(1) Note: CMS computed a monthly 30 day supply based on dosing schedule using the FDA per day estimate based on analysis of IMS Health, National Prescription Audit PlusTM, 1st Quarter 2004; extracted April 2004. Prices are average retail prices (for generic drugs median average retail prices among generic manufacturers was used) in brick-and-mortar pharmacies (i.e. chain, independent and foodstore pharmacies, excluding internet, mail order and long-term care pharmacies) across all payer types (cash-only, Medicaid and other 3rd party payers) for the first quarter of 2004

(2) Data Source: Medicare Price Compare 9/13/04

Table 2a Comparison of Mail Order Prices Under Medicare-Approved Discount Cards vs. Internet Pharmacies [1]

Mail Order Prices for Medicare Approved Drug Discount Cards	Best Price (90 day)	*Percent Savings vs Drugstore.com*	*Percent Savings vs Costco.com*	Internet Pharmacy Prices [2]	
				Drugstore.com (90 day)	Costco.com (90 day) [3]
Aricept (10 mg, 90 tab)	$347.36	-9%	-16%	$379.97	$415.34
Celebrex (200 mg, 90 cap)	$209.35	-8%	-25%	$227.97	$280.27
Fosamax (70 mg, 4 tab--3 packages)	$161.49	-14%	-16%	$187.97	$191.49
Lipitor (10 mg, 90 tab)	$173.95	-5%	-13%	$183.97	$199.05
Nexium (40 mg, 90 cap)	$271.65	-22%	-25%	$346.97	$361.05
Norvasc (5 mg, 90 tab)	$111.20	-10%	-11%	$123.97	$124.80
Plavix (75 mg, 90 tab)	$298.92	-9%	-11%	$329.97	$337.65
Prevacid (30 mg, 90 cap)	$288.88	-16%	-20%	$344.97	$360.60
Protonix (40 mg, 90 tab)	$221.70	-20%	-25%	$276.97	$294.90
Zocor (40 mg, 90 tab)	$239.54	-33%	-34%	$356.97	$362.04
Range of Savings (%) from Medicare Discount Card vs Drugstore.com & Costco.com		**-5% to -33%**	**-11% to - 34%**		

Notes: (1) Data obtained from www.Medicare.gov during the week of 9/13/04 using various zip codes (21045, 15122, 97202, and 38731). Data obtained from Drugstore.com and Costco.com on 9/17/04.
(2) Price data reflect a 90 day supply; they do not include additional shipping, handling or membership fees.
(3) The Costco.com cost is calculated by converting the Internet price for a 100 day supply to a per unit basis and then multiplying the per unit cost by a quantity of 90 (except for Fosamax for which an equivalent comparison was available).

Table 2b Comparison of Retail Prices Under Medicare-Approved Discount Cards vs. Internet Pharmacies [1]

Retail Prices for Medicare Approved Drug Discount Cards	Best Price (30 day)	*Percent Savings vs Drugstore.com*	*Percent Savings vs Costco.com*	Internet Pharmacy Prices [2]	
				Drugstore.com (30 day)	Costco.com (30 day)
Aricept (10 mg, 30 tab)	$126.42	-3%	-10%	$129.99	$140.69
Celebrex (200 mg, 30 cap)	$77.30	-3%	-17%	$79.99	$93.42
Fosamax (70 mg, 4 tab)	$63.00	-5%	-4%	$65.99	$65.89
Lipitor (10 mg, 30 tab)	$64.56	2%	-5%	$62.99	$68.27
Nexium (40 mg, 30 cap)	$104.60	-14%	-14%	$120.99	$122.07
Norvasc (5 mg, 30 tab)	$41.42	-4%	-4%	$42.99	$43.27
Plavix (75 mg, 30 tab)	$110.78	-4%	-3%	$114.99	$114.27
Prevacid (30 mg, 30 cap)	$109.87	-9%	-10%	$120.99	$121.87
Protonix (40 mg, 30 tab)	$86.38	-13%	-14%	$98.99	$100.27
Zocor (40 mg, 30 tab)	$93.76	-24%	-25%	$123.99	$124.87
Range of Savings (%) from Medicare Discount Card vs Drugstore.com & Costco.com		**+2% to -24%**	**-3% to -25%**		

Notes: (1) Data obtained from www.Medicare.gov during the week of 9/13/04 using various zipcodes (21045, 15122, 97202 and 38731).
Data obtained from Drugstore.com and Costco.com on 9/17/04.
(2) Price data reflect a 30 day supply; they do not include additional shipping, handling or membership fees.

TABLE 3a - Low-Income Medicare Beneficiaries' (<=135% FPL) Estimated 4 Month Savings in 2004 (Lowest Price Card)

Illustrative Medicare Beneficiary/Residence	Conditions	Drugs	Dosing	4 Month Estimated Average National Retail Cost[1]	4 Month Estimated Drug Discount Card Cost[2]	4 Month $ Savings From Discount Only	4 Month % Savings From Discount Only	4 Month Total Savings Including $600	4 Month Total % Savings (Discount & $600)
Beneficiary #1									
National	**Market Basket Total**			**$1,454.40**					
Pittsburgh, PA 15122	**Market Basket Total**				**$1,145.20**	**$309.20**	**-21.3%**	**$909.20**	**-62.51%**
Portland, OR 97202	**Market Basket Total**				**$1,139.08**	**$315.32**	**-21.7%**	**$915.32**	**-62.93%**
	Osteoarthritis	Celebrex	200 mg per day						
	Hypercholesterolemia	Zocor	40 mg per day						
	Depression	Paxil	20 mg per day						
	Hypertension	Norvasc	5 mg per day						
Beneficiary #2									
National	**Market Basket Total**			**$522.00**					
Louisville, KY 40205	**Market Basket Total**				**$459.68**	**$62.32**	**-11.9%**	**$476.03**	**-91.19%**
Orange County, CA 90623	**Market Basket Total**				**$459.68**	**$62.32**	**-11.9%**	**$476.03**	**-91.19%**
	Hypertension	Prinivil	20 mg per day						
	Diabetes	Glucophage	850 mg 2x per day						
	Congestive Heart Failure	Lasix	40 mg per day						
Beneficiary #3									
National	**Market Basket Total**			**$1,276.80**					
Boston, MA 02762-Bristol	**Market Basket Total**				**$1,056.40**	**$220.40**	**-17.3%**	**$820.40**	**-64.25%**
Houston, TX 77204	**Market Basket Total**				**$1,056.40**	**$220.40**	**-17.3%**	**$820.40**	**-64.25%**
	Hypertension/mild congestive heart failure	Lisinopril	20 mg per day						
	Coronary artery disease/congestive heart failure	Toprol XL	200 mg per day						
	Hypercholesterolemia	Lipitor	40 mg per day						
	Acid Reflux	Aciphex	20 mg per day						
Beneficiary #4									
National	**Market Basket Total**			**$1,926.00**					
Boise, ID 83714	**Market Basket Total**				**$1,682.76**	**$243.24**	**-12.6%**	**$843.24**	**-43.78%**
Greensboro, NC 27410	**Market Basket Total**				**$1,682.76**	**$243.24**	**-12.6%**	**$843.24**	**-43.78%**
	Schizophrenia	Zyprexa	10 mg per day						
	Hypercholesterolemia	Lipitor	40 mg per day						
	Depression	Zoloft	50 mg per day						
Beneficiary #5									
National	**Market Basket Total**			**$750.00**					
Greenville, MS 38731	**Market Basket Total**				**$651.96**	**$98.04**	**-13.1%**	**$684.80**	**-91.31%**
Arlington, VA 22202	**Market Basket Total**				**$620.04**	**$129.96**	**-17.3%**	**$688.00**	**-91.73%**
	Anticoagulant	Coumadin	2.5 mg per day						
	Osteoarthritis	Vioxx	25 mg per day						
	Osteoporosis	Fosamax	70 mg per week						
Beneficiary #6									
National	**Market Basket Total**			**$1,537.20**					
Clearwater, FL 33767	**Market Basket Total**				**$1,286.68**	**$250.52**	**-16.3%**	**$850.52**	**-55.33%**
Cleveland, OH 44106	**Market Basket Total**				**$1,286.68**	**$250.52**	**-16.3%**	**$850.52**	**-55.33%**
	Diabetes	Glucophage	850 mg 2x per day						
	Diabetes	Actos	30 mg per day						
	Hypercholesterolemia	Pravachol	40 mg per day						

(1) Note: CMS computed a monthly 30 day supply based on dosing schedule using the FDA per day estimate based on analysis of IMS Health, National Prescription Audit PlusTM, 1st Quarter 2004; extracted April 2004. Prices are average retail prices (for generic drugs median average retail prices among generic manufacturers was used) in brick-and-mortar pharmacies (i.e. chain, independent and foodstore pharmacies, excluding internet, mail order and long-term care pharmacies) across all payer types (cash-only, Medicaid and other 3rd party payers) for the first quarter of 2004. This monthly supply estimate was then adjusted to reflect 4 month supply estimate

(2) Data Source: Medicare Price Compare 9/6/04. 30 day supply adjusted to reflect 4 month supply.

TABLE 3b - Low-Income Medicare Beneficiaries' (<=135% FPL) Estimated 4 Month Savings in 2004 (5th Lowest Price Card)

Illustrative Medicare Beneficiary/Residence	Conditions	Drugs	Dosing	4 Month Estimated Average National Retail Cost[1]	4 Month Estimated Drug Discount Card Cost2	4 Month $ Savings From Discount Only	4 Month % Savings From Discount Only	4 Month Total Savings Including $600	4 Month Total % Savings (Discount & $600)
Beneficiary #1									
National	**Market Basket Total**			$1,454.40					
Pittsburgh, PA 15122	**Market Basket Total**				$1,172.24	$282.16	-19.4%	$882.16	-60.65%
Portland, OR 97202	**Market Basket Total**				$1,172.24	$282.16	-19.4%	$882.16	-60.65%
	Osteoarthritis	Celebrex	200 mg per day						
	Hypercholesterolemia	Zocor	40 mg per day						
	Depression	Paxil	20 mg per day						
	Hypertension	Norvasc	5 mg per day						
Beneficiary #2									
National	**Market Basket Total**			$522.00					
Louisville, KY 40205	**Market Basket Total**				$480.28	$41.72	-8.0%	$473.97	-90.80%
Orange County, CA 90623	**Market Basket Total**				$480.28	$41.72	-8.0%	$473.97	-90.80%
	Hypertension	Prinivil	20 mg per day						
	Diabetes	Glucophage	850 mg 2x per day						
	Congestive Heart Failure	Lasix	40 mg per day						
Beneficiary #3									
National	**Market Basket Total**			$1,276.80					
Boston, MA 02762-Bristol	**Market Basket Total**				$1,077.00	$199.80	-15.6%	$799.80	-62.64%
Houston, TX 77204	**Market Basket Total**				$1,077.00	$199.80	-15.6%	$799.80	-62.64%
	Hypertension/mild congestive heart failure	Lisinopril	20 mg per day						
	Coronary artery disease/congestive heart failure	Toprol XL	200 mg per day						
	Hypercholesterolemia	Lipitor	40 mg per day						
	Acid Reflux	Aciphex	20 mg per day						
Beneficiary #4									
National	**Market Basket Total**			$1,926.00					
Boise, ID 83714	**Market Basket Total**				$1,707.80	$218.20	-11.3%	$818.20	-42.48%
Greensboro, NC 27410	**Market Basket Total**				$1,707.80	$218.20	-11.3%	$818.20	-42.48%
	Schizophrenia	Zyprexa	10 mg per day						
	Hypercholesterolemia	Lipitor	40 mg per day						
	Depression	Zoloft	50 mg per day						
Beneficiary #5									
National	**Market Basket Total**			$750.00					
Greenville, MS 38731	**Market Basket Total**				$660.68	$89.32	-11.9%	$683.93	-91.19%
Arlington, VA 22202	**Market Basket Total**				$648.32	$101.68	-13.6%	$685.17	-91.36%
	Anticoagulant	Coumadin	2.5 mg per day						
	Osteoarthritis	Vioxx	25 mg per day						
	Osteoporosis	Fosamax	70 mg per week						
Beneficiary #6									
National	**Market Basket Total**			$1,537.20					
Clearwater, FL 33767	**Market Basket Total**				$1,351.00	$186.20	-12.1%	$786.20	-51.14%
Cleveland, OH 44106	**Market Basket Total**				$1,330.84	$206.36	-13.4%	$806.36	-52.46%
	Diabetes	Glucophage	850 mg 2x per day						
	Diabetes	Actos	30 mg per day						
	Hypercholesterolemia	Pravachol	40 mg per day						

(1) Note: CMS computed a monthly 30 day supply based on dosing schedule using the FDA per day estimate based on analysis of IMS Health, National Prescription Audit PlusTM, 1st Quarter 2004, extracted April 2004. Prices are average retail prices (for generic drugs median average retail prices among generic manufacturers was used) in brick-and-mortar pharmacies (i.e. chain, independent and foodstore pharmacies, excluding internet, mail order and long-term care pharmacies) across all payer types (cash-only, Medicaid and other 3rd party payers) for the first quarter of 2004. This monthly supply estimate was then adjusted to reflect 4 month supply estimate.

(2) Data Source: Medicare Price Compare 9/8/04, 30 day supply adjusted to reflect 4 month supply

TABLE 4 - Price Comparison Retail Pharmacies Drugs for Common Conditions

Illustrative Medicare Beneficiary Condition / Residence	Drugs	Dosing	National Average Retail Monthly Price[1]	Range of Discounts for Top 5 Cards		$ Savings from Discount		% Savings from Discount	
				5th Card Price	Best Price	5th Card Price	Best Price	5th Card Price	Best Price
Acid Reflux									
Boston, MA 02762-Bristol									
	Aciphex	20 mg per day	$135.90	$112.30	$109.93	$23.60	$25.97	-17.4%	-19.1%
Congestive Heart Failure									
Louisville, KY 40205									
	Lasix	40 mg per day	$11.40	$9.58	$7.44	$1.82	$3.96	-16.0%	-34.7%
	furosemide*	40 mg per day	$6.00	$3.87	$2.76	$2.13	$3.24	-35.5%	-54.0%
	Toprol XL	200 mg per day	$58.80	$46.47	$43.94	$12.33	$14.86	-21.0%	-25.3%
	metoprolol*	200 mg per day	$24.60	$7.48	$6.41	$17.12	$18.19	-69.6%	-73.9%
Schizophrenia									
Boise, ID 83714									
	Zyprexa	10 mg per day	$292.80	$261.24	$255.87	$31.56	$36.93	-10.8%	-12.6%
Diabetes									
Cleveland, OH 44106									
	Glucophage	850 mg twice per day	$84.30	$77.57	$76.20	$6.73	$8.10	-8.0%	-9.6%
	metformin*	850 mg twice per day	$38.70	$19.62	$16.90	$19.08	$21.80	-49.3%	-56.3%
	Actos	30 mg per day	$163.50	$138.12	$133.58	$25.38	$29.92	-15.5%	-18.3%
Hypercholesterolemia									
Pittsburgh, PA 15122									
	Zocor	40 mg per day	$136.20	$93.76	$93.76	$42.44	$42.44	-31.2%	-31.2%
	Lipitor	40 mg per day	$106.50	$96.41	$92.36	$10.09	$14.14	-9.5%	-13.3%
	Pravachol	40 mg per day	$136.50	$113.98	$111.89	$22.52	$24.61	-16.5%	-18.0%
Hypertension									
Portland, OR 97202 - Multnomah									
	lisinopril*	20 mg per day	$18.00	$12.20	$9.86	$5.80	$8.14	-32.2%	-45.2%
	Zestril	20 mg per day	$38.40	$30.95	$28.82	$7.45	$9.58	-19.4%	-24.9%
	Prinivil	20 mg per day	$34.80	$32.71	$30.84	$2.09	$3.96	-6.0%	-11.4%
	Vasotec	20 mg per day	$51.30	$47.59	$45.87	$3.71	$5.43	-7.2%	-10.6%
	enalapril*	20 mg per day	$24.30	$8.48	$6.10	$15.82	$18.20	-65.1%	-74.9%
	Norvasc	5 mg per day	$48.60	$43.68	$41.42	$4.92	$7.18	-10.1%	-14.8%
Osteoarthritis									
Greenville, MS 38731									
	Celebrex	200 mg per day	$90.90	$80.79	$77.30	$10.11	$13.60	-11.1%	-15.0%
	Vioxx	25 mg per day	$90.00	$78.93	$77.86	$11.07	$12.14	-12.3%	-13.5%
Osteoporosis									
Greenville, MS 38731									
	Fosamax	70 mg per week	$71.40	$63.71	$63.00	$7.69	$8.40	-10.8%	-11.8%
Depression									
Greensboro, NC 27410									
	Zoloft	50 mg per day	$82.20	$74.35	$67.59	$7.85	$14.61	-9.5%	-17.8%
	Paxil	20 mg per day	$87.90	$74.93	$73.13	$12.97	$14.77	-14.8%	-16.8%

(1) Note: CMS computed a monthly 30 day supply based on dosing schedule using the FDA per day estimate based on analysis of IMS Health, National Prescription Audit PlusTM; 1st Quarter 2004; extracted April 2004. Prices are average retail prices (for generic drugs median average retail prices among generic manufacturers was used) in brick-and-mortar pharmacies (i.e. chain, independent and foodstore pharmacies, excluding internet, mail order and long-term care pharmacies) across all payer types (cash-only, Medicaid and other 3rd party payers) for the first quarter of 2004

(2) Data Source: Medicare Price Compare, at www.medicare.gov, accessed 9/13/04. An asterisk (*) denotes a generic drug.

Mr. FIRMAN. Thank you. I am sure we are going to have questions, but we are going to hold all of the questions until we hear from the four presenters.

Our next presenter is Mary Grealy, the president of the Health Leadership Council, which is a coalition of chief executives of the nation's leading health care companies. Prior to her tenure at HLC, she served as the chief Washington counsel of the American Hospital Association, and prior to that, she was the chief operating officer and executive council of the Federation of American Health Systems.

Ms. Grealy has a bachelor's degree from Michigan State and a law degree from Duquesne University. Welcome.

STATEMENT OF MARY GREALY, PRESIDENT, HEALTH LEADERSHIP COUNCIL

Ms. GREALY. Thank you, Jim.

First of all, I would like to thank Chairman Craig on behalf of the members of the HealthCare Leadership Council for the opportunity to participate in what is a very timely as well as very important forum. This Committee is to be commended for taking action to help Medicare beneficiaries better understand how the Medicare drug discount card program can affect both their health and their finances.

I have submitted a statement for the record today, but I would like to say a few words this afternoon about the study commissioned by the HealthCare Leadership Council. As Jim said, the HLC is a coalition of chief executives of many of America's leading health care companies and organizations, representing all different sectors of health care.

Our guiding mission at the Health Care Leadership Council is accessible, affordable high quality health care for all Americans. Pursuing that goal, we sponsored a study to determine if the Medicare drug discount card program is indeed making prescription drugs more accessible and more affordable for Medicare beneficiaries. We commissioned a highly respected firm, the Lewin Group, to answer a simple yet critical question: would an average Medicare beneficiary, an individual who did not already have some kind of prescription drug coverage, see significant savings by enrolling in the Medicare discount card program?

This is a question that needed to be answered. The discount card program has been the subject of endless political warfare and inflammatory, often misleading rhetoric. We believe that for the sake of seniors and others who are on limited incomes and need help with their prescription purchases, it is time for us to replace rhetoric with indisputable facts.

We asked the Lewin Group to take a look at the impact of the drug discount card, the $600 low-income credit as well as manufacturer assistance programs on the 150 prescription drugs that are most frequently used by senior citizens. We have provided you with that study in its entirety, but allow me to highlight just a few of the key findings. As noted in Figure 11, on the first chart here, Lewin found the Medicare beneficiaries who enrolled in the drug discount card program and began using their cards on July 1 of this year will save an average of $1,247 or 35.5 percent between

that date and the end of 2005, when the program ends to make way for the full Medicare prescription drug benefit.

Those Medicare beneficiaries who have incomes below the 135 percent of poverty level and qualify for the annual low-income credit will save an average of $1,548 over that same 18-month period. On individual prescriptions, the best discount cards nationally will save beneficiaries about 20 percent or an average of almost $10 per prescription, and more than half of the drug discount cards deliver savings of over 17 percent per prescription.

To let you know, by the way, that we found very little variation in the discounted prices between and among geographic regions or between urban and rural areas. The best available price for any medication is generally offered consistently across all markets, and that is unusual for the Medicare program.

Let me touch for a moment on the savings that are being experienced by low-income beneficiaries as well as those that are taking multiple drug regimens for the treatment of chronic diseases. The Lewin findings in this area are striking. Low-income beneficiaries save money not only through the drug discount card; but also through the $600 annual transitional assistance credit. Additionally, a large number of drug manufacturers are offering special assistance to transitional assistance program participants. If a qualifying beneficiary uses up his or her $600 transitional assistance before the end of the year, these manufacturers will make their drugs available at either minimal cost or at no cost at all.

The study shows us an example of how these multiple sources of assistance will help a low-income beneficiary with a chronic condition. We have outlined this in the other chart that is out there, and that is Figure 5A.

For a senior that is afflicted with diabetes and hyperlipidemia or high cholesterol, the average retail spending on the most frequently used drugs for those conditions is $3,337. Now, a beneficiary using the drug discount card alone will save $878. Now, if they use the card and the $600 low-income credit, they will save $1,478. A beneficiary using the card, the low-income credit and manufacturer assistance program for those drugs will save $2,198, or 66 percent off the average retail price.

We are very pleased to present this comprehensive study on the drug discount card, and we encourage everyone to share these findings with your colleagues and for Members of Congress to share it with their constituents. We will be disseminating this information as well through a new coalition called Medicare Today. Medicare Today is made up of over 100 organizations representing seniors, health care providers, consumers and employers, and is dedicated to helping beneficiaries take full advantage of the new programs passed by this Congress, and we certainly look forward to working with Jim Firman and the ABC Coalition and others in the many months ahead.

It is regrettable that there are seniors who have been dissuaded by the political controversy from enrolling in a program that can make a significant difference in their daily lives. It is our hope that by placing this information in the public domain that we can encourage beneficiaries, particularly those on low or fixed incomes, to

take advantage of this program and begin saving substantial money on their medications.

For seniors that have not enrolled, every day that goes by represents money that they are leaving on the table, and that money cannot be recouped. So we want to make sure that that does not happen.

Again, we look forward to working with all of the panelists and making sure that we get this information out there to those that can use it. Thank you.

[The prepared statement of Ms. Grealy follows:]

Statement of

Mary R. Grealy
President
Healthcare Leadership Council

Before the

United States Senate Special Committee on Aging
Forum on
Recent Analyses of the Medicare Prescription Drug Card
and Transitional Assistance Programs

September 23, 2004

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Chairman Craig, Senator Breaux and members of the committee, I want to thank you, on behalf of the members of the Healthcare Leadership Council, for the opportunity to participate in this very timely and very important forum. This committee is to be commended for convening an event that will help give Medicare beneficiaries essential information about a program that can affect both their health and their finances.

It would seem implausible that there would be controversy over the Medicare prescription drug discount card and the accompanying transitional assistance programs. After all, who could possibly be critical of a program that is intended to save seniors money on their prescription drug purchases, and that offers considerable assistance to beneficiaries with low incomes? And yet, there has been controversy. There has been heated political rhetoric about the program. And, consequently, it would not be surprising if some senior citizens and Medicare-eligible disabled individuals are confused as to whether it is advisable or worthwhile to enroll in the Medicare drug discount card program.

That's why today's forum is so valuable. We have an opportunity to place objective facts on the table, to enable beneficiaries to see whether or not this program will be of benefit to them.

Before I discuss the economic study that the Healthcare Leadership Council is contributing to today's discussion, let me first explain the perspective we bring to this issue.

The Healthcare Leadership Council is a coalition of chief executives of many of the nation's premier health care companies and institutions. It is an organization dedicated to the pursuit of policies and legislation that will make health care more affordable, more accessible, and of the greatest achievable quality. On this particular issue, it is important to note that HLC has among its members a number of pharmaceutical manufacturers. Our membership also includes a large number of direct providers of health care, institutions that have a strong interest in purchasing prescription drugs at the lowest possible price. Because of our diverse membership, the Healthcare Leadership Council comes to this issue with no preconceived agenda other than helping Medicare beneficiaries have the facts that will make them more effective health care consumers.

When the drug discount card enrollment period began and the political debate intensified, Americans – particularly Medicare beneficiaries – heard or read numerous comments that the cards simply weren't worth it. Many were also concerned that it would be too much of a hassle to apply and that they would see little or no savings anyway. That begged the question – would an average Medicare beneficiary, a man or woman who didn't already have some kind of prescription drug coverage, see significant savings by enrolling in the drug discount card program? Rather than engage in the political crossfire taking place over this initiative, the members of the Healthcare Leadership Council thought we should simply attempt to answer that core question.

So we engaged The Lewin Group to assist us in this task. We chose Lewin because of the firm's experience and expertise in consulting on health and human services issues. Just as importantly, though, we selected The Lewin Group to perform this study because of its well-earned reputation for a non-partisan, non-ideological, strictly analytical approach to questions such as this. We were determined that the results of this study would be beyond reproach.

We asked Lewin to take a real-world approach to the drug discount card issue. Specifically, the study we commissioned compares Medicare discount card prices, as posted on the CMS website, to average retail prices in each state for the 150 prescription drugs most commonly used by senior citizens. Lewin also compared prices for a market basket of the 25 most-frequently-prescribed drugs for Medicare beneficiaries, and also for typical multiple-drug regimens used to treat common chronic diseases. Finally, we also looked at the full impact being experienced by low-income seniors who use both the drug discount card as well as the Medicare transitional assistance program and manufacturer assistance programs.

We collected the price data from the Medicare website during the first and second weeks of June 2004 as beneficiaries were beginning to enroll in the program. Then, Lewin went back and collected the information again during the last week of July to ensure that prices had not significantly changed. They had not. Estimates of overall savings were basically the same in July as they were in June.

Mr. Chairman, the full Lewin Group study and accompanying tables have been made available to the committee. The material is also available to the public through the Healthcare Leadership Council website (www.hlc.org). In my statement today, I would like to highlight some of the key findings of this study.

Overall Per Capita Savings

Medicare beneficiaries who enrolled in the drug discount card program and began using their cards on July 1, 2004 will save an average of $1,247, compared to their median current retail spending of $3,514. Those who have incomes below 135 percent of poverty and qualify for the $600 annual low-income credit will save an average of $1,548 over that same 18-month period running through the end of the program in December 2005.

Let's look at savings on individual prescriptions. Nationally, the best discount cards will save beneficiaries an average of almost $10 per prescription, representing a discount of just over 20 percent. We know that not every Medicare beneficiary will have the best possible card although, because of the way the CMS website and telephone assistance programs are structured, beneficiaries will receive one of the best cards for their specific medication needs. But, even if a beneficiary doesn't have the best possible card, significant savings will still be achieved. More than half of the drug discount cards deliver savings of over 17 percent, or $8.48 per prescription.

As noted earlier, we wanted this to be a study with real world impact, reviewing the actual drugs that senior citizens are using everyday. We found that, surveying the most-frequently-used 150 drugs, the best available price from any card sponsor represents an average savings per prescription of $17.37, or 23 percent.

It should be noted that there is very little variation in discounted prices between rural and urban regions. In fact, the best available price for any medication is generally offered consistently across all markets. Where we do see per capita savings variations is in states that have a higher proportion of low-income seniors. In Louisiana, for example, seniors are saving on average $1,902 from July 1, 2004 to the end of 2005, when the program concludes, compared the national per capita average of $1,247.

Savings for Beneficiaries with Chronic Diseases Requiring Multiple-Drug Regimens

Continuing to measure the real-world impact of the drug discount card program, we also asked The Lewin Group to examine the level of savings for seniors who are taking multiple medications for common chronic diseases. In this case, savings for each of the drug regimens were estimated by collecting drug prices using a single discount card at a single pharmacy. We also used, for calculation purposes, the most frequently prescribed drugs for these chronic conditions.

We have found, for example, that a senior citizen with hypertension, taking two hypertension drugs and a diuretic, would normally pay $921 annually for those medications at average retail prices. Using the Medicare-approved drug discount card, that beneficiary would save $254, or 28 percent on that drug regimen.

A senior citizen afflicted with diabetes and hyperlipidemia using the Medicare-approved card will save $878 on average retail spending of $3,337, for a savings of 26 percent. A patient taking three commonly prescribed drugs for coronary artery disease will save $531 using the Medicare-approved card on average retail spending of $2,562 for savings of 21 percent.

An even greater impact is seen when low-income seniors use the drug discount card, Medicare transitional assistance and drug manufacturer assistance programs.

Savings for Low-Income Beneficiaries

In addition to the savings provided by the Medicare-approved drug discount cards, beneficiaries with low annual incomes have two additional sources for savings. Beneficiaries with incomes below 135 percent of poverty are eligible to receive a $600 annual federal credit. It is possible for eligible seniors to receive $1,200 in credits over the life of the discount card program.

Additionally, a number of drug manufacturers are offering new low-income assistance programs to participants in the drug discount card program. In short, if a beneficiary

uses up his or her $600 transitional assistance credit before the end of the year, these manufacturers make drugs available at either minimal cost or no cost at all. There are at least 35 discount cards that participate with one or more manufacturer programs. If an eligible beneficiary is enrolled with one of these 35 discount cards, then they are automatically enrolled in the applicable manufacturer assistance program.

The impact of this combined assistance is substantial. Take, for example, the savings experienced by an eligible senior suffering from diabetes and hyperlipidemia. As mentioned earlier, a beneficiary using only the discount card will save $878 on average annual retail spending of $3,337. A beneficiary with the card and the $600 low-income credit will save $1,478. And, a beneficiary using the card, low-income credit and manufacturer assistance program will save $2,198, or 66 percent off the average retail price.

Even if you take the manufacturer assistance program out of the equation, the savings are substantial. A senior citizen with hypertension, as mentioned earlier, will pay an average of $921 per year for their drug regimen. Using the discount card and the $600 low-income credit, that beneficiary will pay only $67 per year, a savings of 93 percent.

National Aggregate Savings

Seniors and Medicare-eligible disabled individuals will save, collectively, billions of dollars on their prescription drug purchases over the course of the drug discount card program.

The Lewin Group study estimates that, if enrollment continues at its current pace, beneficiaries will experience an aggregate savings of $7.7 billion over an 18-month period. This figure is reached, Mr. Chairman, by using conservative assumptions. If we calculated aggregate savings using the assumption that every beneficiary would choose the very best discount card, the aggregate total would actually be $8.7 billion. We are instead assuming that enrollees will select drug discount cards in the 75th percentile with average savings of 19.9 percent.

Conclusion

This comprehensive study has enabled us to answer the question, "Is it worthwhile for Medicare beneficiaries without prescription drug coverage to enroll in the drug discount card program?" The study results tell us conclusively that seniors will, on average, experience savings of approximately 20 percent on their prescriptions, and will save hundreds of dollars on their medication purchases over the life of the program. Furthermore, low income seniors will see their drug costs frequently cut by more than half when using the discount card, the $600 federal credit and manufacturers assistance programs.

The Lewin Group study did not address the discount card enrollment process, but a point needs to be made here as well. The Centers for Medicare and Medicaid Services

deserves considerable credit for its responsiveness to beneficiary concerns, expressed in the initial days of the enrollment process, over the complexity of the program. CMS has taken steps to simply and improve its Internet-based program and has added additional customer service representatives to assist those who use the toll-free 800 number, 1-800-MEDICARE.

It is simply wrong for any individual or organization to discourage a Medicare beneficiary from applying for a discount card using the arguments that it is too complicated or that it will generate little in the way of savings. The Lewin Study shows compellingly that the discount cards are generating substantial savings, and any senior citizen that wants to enroll without using the Internet can do so by speaking to a trained customer service representative.

Mr. Chairman, for seniors who have not enrolled in this program and who have no other form of prescription drug coverage, every day that goes by represents money they are leaving on the table that cannot be recouped. It is regrettable if there are seniors who have been dissuaded by political controversy from enrolling in a program that can make a substantial positive difference in their lives. It is our hope at HLC that by putting this information into the public domain, and through efforts and initiatives like those undertaken by this committee, we can encourage seniors – particularly those with low or fixed incomes – to take advantage of this program and begin saving money on their essential prescription drug purchases. Thank you very much.

Mr. FIRMAN. Thank you, Mary.

Our next presenter is Robert Helms, who is the resident scholar and director of health policy studies at the American Enterprise Institute. He has been there for about 11 years, if I do my math right. Prior to that, he was the executive director of the American Pharmaceutical Institute, and before that, he was assistant secretary for planning and evaluation in the Department of Health and Human Services from 1984 to 1989.

Dr. Helms has a Ph.D. and an M.A. in economics from the University of California and his bachelor's degree from Auburn University.

STATEMENT OF ROBERT HELMS, RESIDENT SCHOLAR AND DIRECTOR OF HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE

Mr. HELMS. Thank you, Jim.

I would like to thank the Committee for the invitation. I am happy to present this study. It is in your packets and also on the AEI Website. This study was done by Joe Antos and Ximena Pinell back in June, and it was published by AEI in June.

I am also going to report on some of the updates that we have done since then. It is a straightforward study, somewhat similar to the others. I might say that compared to these other studies, we do not have as many numbers as the other people, but we certainly have the best looking publication.

With the advice of some physicians, we assigned the most commonly used drugs to these hypothetical patients on Medicare. We think we have a good sample.

We then looked up the prices of these drugs in the retail market, and in the mail order market, as listed on the CMS Website as of June 1. Since then, we have updated these prices on a number of different locations.

As figure 2 shows, like the other studies, that for a 7-month supply—we are looking at from June through the end of 2004, if people go in without any coverage and without any kind of discount card, they would pay full retail prices, would spend $2,073. The Medicare retail price, using the card, they would spend only $495. The savings, which are almost $1,600, come from, primarily, $600 for the subsidy for the people who are eligible for this, $575 of discounts from the Medicare program and then $403 from the special manufacturer savings.

So, for the neediest seniors, those who are below the poverty thresholds $12,570 for individuals, $16,862, for couples, and without drug coverage these are substantial savings. But as you see in Figure 3, they can save even more; it is consistent with the other studies. This shows our evidence from several different—the estimated retail at $2,073 on the left, the 7-month supply; if you went and got it from CVS mail order, AARP retail, the Costco mail order, the AARP mail order, but also, that the lowest of those, the AARP mail order, would be $1,500 for the period of time, and for the Medicare retail, it would go down to $495. But if you were willing to go to mail order with the Medicare discount card, you could get that down to $388, a savings of 81 percent for this senior.

Now, this is not to say that everybody wants to go to the trouble of going to mail order or Canada. For a lot of people, the price is not the only thing they value. The convenience of going to their local pharmacist and dealing with somebody they know is very valuable for many people. So it is not the only thing that people have in mind.

Figure 4 shows the savings that people could get who are not eligible for the $600 subsidy who are just the higher-income beneficiaries. Here, you can see that compared to $2,073 that they would have to pay with full retail price, and the best they could presently get, well, for AARP retail would be $1,787, and the AARP mail order would be down to $1,664. But with the Medicare card, they could get this down to $1,575 at retail level, but if they were willing to go to the Medicare mail order, they could get it down to $1,322.

Now, as you can see in the last bullet, we did some updates of this as of last Tuesday, 2 days ago, and the best prices there for the Medicare retail go to $1,552, a slight decline, and for the Medicare mail order, it goes down from $1,322 down to $1,264. So, rather than prices are going up, our best indications are that there are probably small declines in prices. This is consistent with what you would expect in a competitive market in what is going on here, because our perception is that people are using this program, the cards to get ready for part D, which starts in 2006, so they have very strong commercial incentives to get more people on their card and keep them there.

Now, Figure 5 just looks at, identifies the top five drugs. We use the Families USA selection of those drugs, and in the next table, Figure 6, here, you have the price, the range of savings for the price differences for the individuals who are the comparison for an individual pharmacy; in other words, the individual walking into a retail pharmacy without a card versus what they could get at the same pharmacy with the card.

We have made this comparison in more places than we have listed here. Our conclusion is that the savings that are available through the Medicare discount card program are similar throughout the country, and the range of savings presented in this chart represent discounts off full retail prices. They range from 8 to 36 percent.

Summing up, the Medicare prescription drug discount card program is a very good deal for most seniors. We find savings as high as 36 percent off the full retail prices and consistently around 30 percent around the country. The low income seniors can save considerably more by taking advantage of the $600 subsidies throughout the rest of this year and $600 throughout 2005. They can save 50 to 75 percent by having the card compared to not having it.

Since the program started on June 1, there is no evidence of card sponsors dropping drugs from their formularies or raising their drug prices once seniors are enrolled. In fact, as I said before, we have seen some evidence that the prices seem to be declining even since June. We have also found is that most cards offer nearly equivalent savings to seniors. In Boise, ID, for example, 31 of 33 available card plans price a top-selling set of drugs within 10 percent of the absolute best deal.

That shows us that while it is important to shop around, people should not worry too much about getting the absolute best card; just get a card and you will get most of the savings.

The bottom line? Most seniors can get substantial savings by signing up for one of the discount cards. They can get most of these savings at the local pharmacy if they do not want to deal with mail order, or if they do not want to deal with going to some foreign source of drugs. Almost all of the savings can be obtained from all the cards, so it is more important to get a card than it is to worry about getting the best card.

Let me add, as an economist who has been studying this pharmaceutical industry for years, my view is that a lot of things are changing about the economics of this industry. The price transparency that we are going to get in Medicare is going to have a larger effect than just the Medicare market. I think it is going to speed up the rate of change that the market is imposing on this industry now.

So, thank you.

[The prepared statement of Mr. Helms follows:]

Robert B. Helms
Resident Scholar and Director of Health Policy Studies
American Enterprise Institute

Forum: Medicare Drug Discount Cards: Measuring the Savings
U.S. Senate Special Committee on Aging

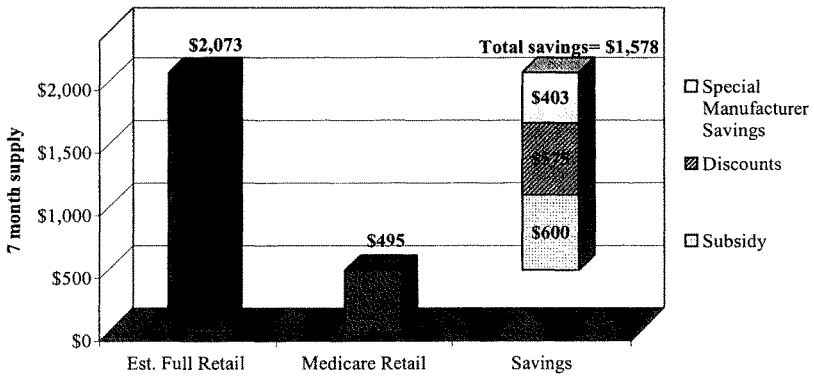
Thursday, September 23, 2004

Figure 1. Three Hypothetical Beneficiaries

	Age	Conditions	Prescription Drugs
Robert Smith	66	Diabetes High blood pressure High cholesterol Erectile dysfunction	Glucophage metoprolol Zocor Viagra
Mary Jones	74	Congestive heart failure High blood pressure High cholesterol Osteoarthritis Gastric reflux disease	Lasix metoprolol, Zestril Lipitor Vioxx Prevacid
Fred Green	78	Chronic lung disease Blood clots Seasonal allergies Hypothyroidism Depression	albuterol Coumadin Allegra Levoxyl Paxil

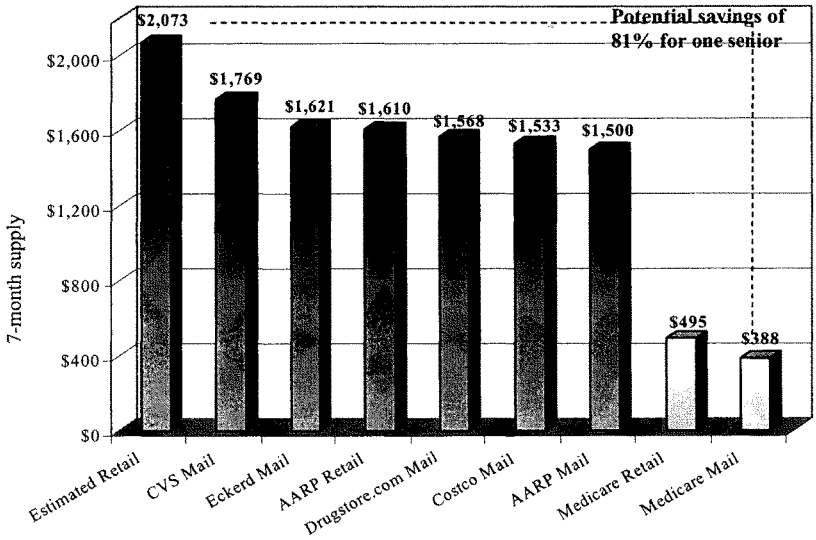
- These patient profiles were designed with the advice of two physicians.
- They represent conditions typical of the elderly and medicines often prescribed to treat those illnesses.

Figure 2. Source of Medicare Savings off Full Retail Price For a Low-Income Beneficiary



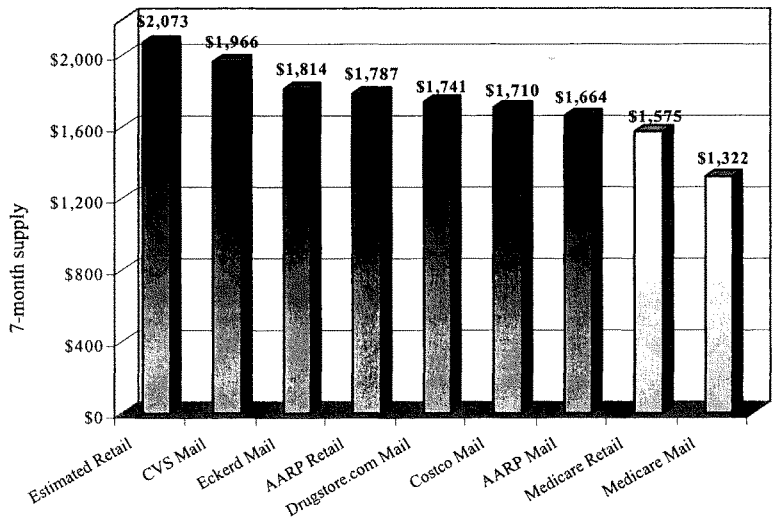
- The neediest seniors—those with incomes below $12,569 for individuals, $16,862 for couples) and without drug coverage—can save hundreds of dollars this year on the cost of their prescriptions.

Figure 3. Big Savings for Low-Income Beneficiaries



- Low-income seniors (incomes below $12,569 for individuals, $16,862 for couples) who do not have drug coverage can benefit from the $600 subsidy, discounts, and special savings from drug manufacturers.
- For the remainder of this year, those seniors could save between 50 and 78% off the best private deals available to them outside of Medicare.
- They could save 62 to 83% compared to full retail prices.

Figure 4. Significant Savings Even for Higher-Income Beneficiaries



- Higher-income seniors (incomes above $18,620 for individuals, $24,980 for couples) without drug coverage could save 6 to 24% this year off the best private deal available to them outside of Medicare.
- Those seniors could save 14 to 35% compared to full retail prices.
- Prices above are from June 1. On September 21, the best retail price for this set of drugs available through a Medicare card was $1,552 for a 7-month supply. Medicare's best mail-order price for these drugs was $1,264.

Figure 5. Top Drugs Used by the Elderly

Brand-Name Drug	Strength	Dose Form	Marketer
Lipitor	10 mg	tab	Pfizer
Plavix	75 mg	tab	Bristol-Myers Squibb
Fosamax	70 mg	tab	Merck
Norvasc	5 mg	tab	Pfizer
Celebrex	200 mg	cap	Pfizer

Source: Families USA, *Sticker Shock: Rising Prescription Drug Prices for Seniors*, June 2004, available at www.familiesusa.org/site/DocServer/Sticker_Shock.pdf?docID=3541.

Figure 6. Savings Available through Medicare Discount Cards on Top 5 Drugs

City	Date	Range of Savings
Charleston, West Virginia	August 9	22-31%
Des Moines, Iowa	August 30	20-28%
Omaha, Nebraska	September 1	15-27%
Albuquerque, New Mexico	September 13	23-36%
Boise, Idaho	September 20	8-19%
Concord, New Hampshire	September 21	24-32%
Fox Lake, Illinois	September 21	16-29%

- Savings available through the Medicare discount card program are similar throughout the country.
- The ranges of savings presented above represent discounts off full retail prices.

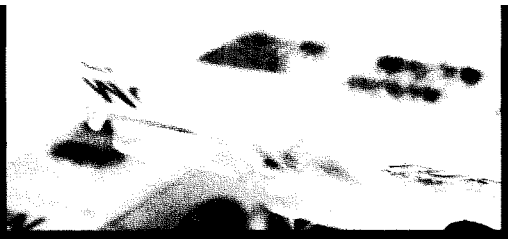
Highlights

- The Medicare prescription drug discount card program is a very good deal for seniors. Savings as high as 30 percent off full retail prices have been seen across the country for sample drug sets used frequently by seniors.

- Low-income seniors can save considerably more. In addition to discounts available through the Medicare cards, they are also eligible for special manufacturer savings programs and $600 subsidies in 2004 and 2005. Between June and December, low-income seniors can save between 50 and 74 percent of their drugs costs compared to their best alternatives outside Medicare. That can translate into savings of $1,000 or more in 2004 alone, and more savings in 2005.

- Since the program's start on June 1, there is no evidence of card sponsors dropping drugs from their formularies or raising their drug prices once seniors enrolled. In fact, we have seen prices decrease somewhat since June.

- Most cards offer nearly equivalent savings to seniors. In Boise, Idaho, for example, 31 of 33 available card plans price a top-selling set of drugs within 10 percent of the absolute best deal.



Private Discounts, Public Subsidies

HOW THE MEDICARE PRESCRIPTION DRUG DISCOUNT CARD REALLY WORKS

JOSEPH ANTOS *and* XIMENA PINELL

54

Private Discounts, Public Subsidies

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Joseph Antos
Ximena Pinell

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Contents

List of Illustrations v

Acknowledgments vii

Introduction 1
- Origins of the Discount Card Program *3*
- Plan of the Study *4*

Discount and Assistance Programs Available Outside Medicare 5
- Discount Programs Sponsored by Organizations Other than Pharmaceutical Manufacturers *5*
- Senior Discount Card Programs Sponsored by Pharmaceutical Manufacturers *6*
- Patient Assistance Programs Sponsored by Pharmaceutical Manufacturers *8*
- State Pharmacy Assistance Programs *8*

The Medicare Prescription Drug Discount Card Program 11
- Medicare Drug Discount Cards *11*
- Transitional Cash Assistance *12*

Finding the Best Deal 14
- Three Typical Beneficiaries *15*
- Choosing the Right Medicare Discount Card *20*

Prospects for Success 23
- Encouraging Enrollment *24*
- Competition vs. Regulation *25*
- Catalyst for Change *26*

Appendix 28

Notes 35

About the Authors 37

Illustrations

TABLES

1. Various Senior Discount Card Programs *7*
2. State Pharmacy Assistance Programs *9*
3. Three Hypothetical Beneficiaries *15*
4. Medicare Savings off the Best Private Deal *18*
5. The Top Five Medicare Discount Card Options for Mrs. Jones *22*

A1. Three Typical Beneficiaries *28*
A2. Prescription Drugs Used by Our Beneficiaries *29*
A3. Prescription Drug Discounters *30*
A4. Savings Available under Medicare Discount Card by Income Level *31*
A5. Manufacturers' Senior Discounts Available to Low-Income Beneficiaries in the Study *31*
A6. How Much Can Low-Income Seniors Save on a Seven-Month Supply of Their Medicines? *32*
A7. How Much Can Moderate-Income Seniors Save on a Seven-Month Supply of Their Medicines? *32*
A8. How Much Can High-Income Seniors Save on a Seven-Month Supply of Their Medicines? *33*

FIGURES

1. Mr. Smith Can Save 75 Percent over the Next Seven Months *16*
2. Mr. Smith's Best Deals *17*

Acknowledgments

This study would not have been undertaken without the untiring efforts over many years of Grace-Marie Turner, president of the Galen Institute. Grace-Marie was the first to champion a consumer-oriented drug benefit for seniors nearly four years ago. The Medicare prescription drug discount card program that is operating today owes its existence in no small measure to her efforts to educate policymakers and the public about this new approach to Medicare benefits. Her contribution to this study extends well beyond the usual round of comments and suggestions that one gratefully accumulates when engaged in such a project.

Several others provided valuable assistance to the authors at critical junctures in the development of the study. Jack Calfee, Scott Gottlieb, Robert Helms, and Richard Manning provided numerous helpful comments on the draft. Two physicians, who will remain anonymous, helped us develop the clinical profiles of the hypothetical Medicare beneficiaries used to estimate the value of the new program. Jenna Persico, Tara Persico, and Nikhil Pandey helped to collect data on pharmaceutical prices from online sources.

Introduction

Not good enough. Too complicated. A program that will benefit drug companies more than it will benefit seniors.

These charges have been leveled at the new Medicare prescription drug discount card program that began in June. That program, part of the $400 billion prescription drug benefit and Medicare modernization bill signed into law in December 2003, is a short-term measure to provide financial assistance to seniors and disabled Medicare beneficiaries for the purchase of their prescription drugs.[1] Despite the early criticisms, the program is already having a favorable impact on beneficiaries.

The drug discount card program is designed to bring the benefits of group purchasing to seniors, resulting in lower prices at the pharmacy. It also offers cash assistance to low-income seniors who have no other insurance coverage for prescription drugs. In addition, needy seniors benefit from special discounts offered by pharmaceutical manufacturers through the Medicare-approved card.

Many critics wasted no time in pronouncing the Medicare discount card program a failure. Some claimed the discounts under the program would be inadequate months before those discounts could be known:

- On December 10, just two days after the president approved the new Medicare legislation, Sen. Edward Kennedy (D-Mass.) complained that the discount card program would "put corporate profits ahead of patients' needs" because it did not impose government controls on the size of the discounts.[2]
- Six Democratic House members—John Dingell of Michigan, Henry Waxman and Pete Stark of California, Charles Rangel of New York, Sherrod Brown of Ohio, and Mike Ross of Arkansas—repeated this theme in January. They asserted that the "drug discount cards do not provide prices that are significantly lower than those already available to seniors."[3]

Others complained about the complexity of the new program. They argued that seniors would be confused by having to choose from too many Medicare discount card options:

- The *New York Times* in early February summarized the concerns of consumer advocates that seniors "will face a bewildering array of new government-approved drug discount cards."[4]
- In late February, Ron Pollack, executive director of Families USA, said "seniors all across the country are confused, bewildered, and perplexed by the new legislation and have a very

difficult time navigating the choices that are in their best interest."[5]

Were the critics correct? The Medicare drug discount card program began to enroll beneficiaries on May 3, and seniors began to use their cards on June 1. Rather than speculating about how the program might function, it is now possible to do an early assessment of the program based on its actual performance.

The card program should be evaluated on its own terms, not criticized because it does not do what it was not designed to do. Bear in mind that the Medicare discount card program is not the full Medicare drug benefit. It was intended by Congress to help Medicare beneficiaries only until the full benefit becomes available, with the greatest assistance to low-income beneficiaries without drug coverage. Seniors have almost nothing to lose by enrolling in the program—the annual enrollment fee is $30 or less—and potentially much to gain in reduced prescription costs. The program is temporary, however, and it cannot resolve every drug financing problem in Medicare.

Despite complaints that the Medicare prescription drug discount card program is inadequate, the program provides substantial help with the cost of prescriptions to millions of seniors and disabled beneficiaries. Discounts negotiated by the card sponsors are only part of the story. Low-income seniors without other drug coverage also receive a $600 annual cash subsidy and special discounts made available by pharmaceutical manufacturers. Beneficiaries who need the help the most could save between half and three-quarters of their prescription cost for the remainder of this year through this public-private partnership. The Medicare drug discount card program was designed by Congress primarily to help low-income seniors, and with private sector involvement, that is precisely what it achieved.

The influence of the discount card program is likely to extend well beyond temporary assistance for several million Medicare beneficiaries. Congress opened the door to competition among private plans through the drug discount card program. For the first time, consumers can compare pharmaceutical prices available through the card anywhere in the country and shop for the best value. Employers, insurers, and individuals who are not in the Medicare program also can compare Medicare's best prices with the prices they currently pay. That new price transparency ultimately could enhance competition and leverage change throughout the pharmaceutical industry, benefiting all consumers.

The new program has had growing pains—not surprising given the short six-month window allowed by Congress to have the program up and running. The consumer information campaign rolled out unevenly. Television advertising meant to build public support and awareness of the new drug benefit was slowed by criticisms from political opponents, who demanded an investigation by the General Accounting Office. An internet site containing information on drug prices available through each Medicare discount card had a rocky start, with complaints that some of the prices were inaccurate and hard to access. Early reports indicate slow growth in enrollment, although that is likely to pick up in the coming months with more aggressive outreach and consumer information efforts.

For many Medicare beneficiaries, the decision to enroll in the Medicare drug discount card program should be easy. They generally have many options, each of which offers similar savings. Complexity arises for beneficiaries who are eligible for pharmaceutical manufacturers' special discounts, available to low-income seniors who have no drug coverage. Those beneficiaries could select a Medicare card that provides some savings without much difficulty. They could save hundreds of dollars a month more through special manufacturers' discounts, but that would require greater efforts to find the best deal. The current failure to offer clear and accessible information on the coordination of the Medicare discount card and manufacturers' separate discount programs must be corrected if the new Medicare program is to live up to its full potential.

Origins of the Discount Card Program

It is commonly believed that seniors as a group pay the highest prices for prescription drugs. In fact, very few people at any age pay the full retail price for prescription drugs. Most seniors are enrolled in private or public health insurance plans—retiree health plans, Medicaid, or Medigap—that cover prescriptions. Those plans negotiate discounts with pharmaceutical manufacturers, and their beneficiaries are responsible for an out-of-pocket payment that is a fraction of the total negotiated price of the drug. Others without such coverage can cut their costs through discounts offered by many retail pharmacies, associations such as AARP, pharmaceutical manufacturers, and internet pharmacies. Perhaps 10 million Medicare beneficiaries currently have no prescription drug coverage. Many of them and others with only modest drug coverage have trouble paying their drug bills.

As the cost of pharmaceuticals rises, some seniors turn to Canada and other countries for their prescription drugs. The Food and Drug Administration, major pharmaceutical manufacturers, pharmacists, and others have raised concerns about the safety and effectiveness of drugs that reach consumers from those foreign sources.

The absence of a prescription drug benefit in Medicare is a significant gap in the program that has been widely noted since its beginnings in 1965. Congress enacted a drug benefit in the Medicare Catastrophic Coverage Act of 1988, but a storm of protest from seniors over the high cost of premiums led to its repeal in 1989. The issue was rejoined in 1999 when then-President Bill Clinton proposed a drug benefit costing $168 billion over ten years.

In an effort to give all Medicare beneficiaries the advantage of price discounts through group purchasing, President George W. Bush, on July 12, 2001, announced a new Medicare-endorsed prescription drug discount card program. That initiative, vigorously promoted by Thomas Scully, then administrator of the Centers for Medicare and Medicaid Services (CMS), was a stopgap measure intended to help seniors until a full prescription drug benefit could be passed by Congress. Unlike the current program, no funds were made available to subsidize the purchase of prescription drugs by low-income seniors.

Less than a week later, the National Association of Chain Drug Stores (NACDS) and the National Community Pharmacist Association filed suit in U.S. District Court to block that program on the grounds that any consumer savings would come straight out of the pockets of pharmacists. Subsequent efforts over several years to implement the discount card program without new legislative authority failed.

That same year a proposal for a funded discount card was advanced by policy analysts at the American Enterprise Institute and the Galen Institute.[6] That proposal was intended to be the vehicle for the full Medicare drug benefit, rather than serve as a temporary measure. It combined a discount card, a cash subsidy for low- and moderate-income seniors, and catastrophic insurance coverage offered as a package by competing private firms. Such an approach offered strong incentives to hold down unnecessary costs while providing financial support targeted to those who were most in need.

By 2003, a narrow consensus had formed in Congress that a Medicare drug benefit could and should be enacted. The Medicare Prescription Drug, Improvement, and Modernization Act was signed into law on December 8 of that year. According to the Congressional Budget Office (CBO), the new drug benefit will cost $409 billion between 2004 and 2013.[7] The Office of Management and Budget pegs the cost at $534 billion.

Controversy raged over the role of competition in a modernized Medicare program, but in the final bill, the drug benefit was to be delivered through competing private plans. That decision remains a sore point for many politicians.

Recognizing that a full drug benefit could not be implemented for several years, Congress created the Medicare prescription drug discount card program, including cash assistance for low-income beneficiaries, that operates today. Even though the Medicare prescription drug discount card program is temporary, it is a proving ground for the full drug benefit,

scheduled to begin in 2006. This temporary program also operates through competing private discount card sponsors, and as such, it has drawn considerable scrutiny and criticism from those who prefer a more traditional government-run benefit. Any failures in the discount card program will serve as evidence to critics that a competitive system does not work in Medicare.

Plan of the Study

Will the Medicare prescription drug discount card program be a success? We focus on how much beneficiaries might save over the remainder of 2004 by enrolling in a Medicare-approved discount card plan. Estimates are based on the prices of prescription drugs posted on the Medicare website www.medicare.gov as of June 1, the first day that discounts were available to seniors under the new program. Although prices are likely to change over the year, these data provide a reasonable early indication of how well seniors might do under a Medicare discount card compared to their other alternatives for discounted drug prices. This is the same information many seniors themselves are reviewing as they consider whether to enroll in the program.

As background to this analysis, the next section discusses discount and subsidy programs outside the Medicare program available to help seniors with the cost of their prescriptions. The section after that summarizes the provisions of the Medicare drug discount card program and briefly explains how the non-Medicare savings options dovetail with the Medicare program.

Then, we analyze the costs that three typical beneficiaries will pay for prescription drugs this year under the Medicare drug discount card program. Those individuals have health conditions that frequently occur in an elderly population, such as hypertension, diabetes, and congestive heart failure. We investigate several ways in which they can reduce their out-of-pocket spending for prescription drugs, including switching from brand-name pharmaceuticals to their generic equivalents and purchasing through a mail order service rather than at a retail pharmacy. We compare the amounts spent by each person under the Medicare drug discount card program with the spending they would incur using alternative discount and subsidy programs currently available to seniors. Our evaluation of the program, therefore, is against the discounts that a savvy shopper could obtain outside of Medicare.

The concluding section provides a broader assessment of the likely performance of the Medicare drug discount card program. Will the prices we see today remain relatively constant over the year, or will they rise sharply once seniors are locked into specific drug discount cards? Can seniors be sure that the drugs they use will remain available to them at low prices over the entire year? If the program is successful, will funded discount cards remain available after the full Medicare drug benefit begins in 2006? How might the Medicare drug discount card program affect the broader market for pharmaceuticals? Will Congress allow this program to succeed?

Discount and Assistance Programs Available Outside Medicare

Prescription drugs pose a large and growing cost to many seniors. Various options are available to seniors to make their drug bills more affordable, however. Lower prices are available through

- Discount programs sponsored by organizations other than pharmaceutical manufacturers. These can be administered by associations (such as AARP), pharmacies (such as Eckerd), pharmacy benefits managers (such as ExpressScripts), and online pharmacies (like Drugstore. com). Many of these programs offer mail order services that can increase savings to consumers.
- Senior discount card programs sponsored by pharmaceutical manufacturers. Low- and moderate-income seniors often can obtain very large savings through such programs.
- Patient assistance programs (PAPs) sponsored by pharmaceutical manufacturers. These programs make drugs free to low-income patients of all ages.
- State pharmacy assistance programs. Many state governments subsidize or obtain discounts on prescription drugs for their residents without drug coverage.

Most of the existing programs and purchasing options will remain available to seniors and other consumers now that the Medicare prescription drug discount card program is available. In many cases, seniors will be able to use a combination of programs with the Medicare discount card to get the best deal on their prescription drugs.

Discount Programs Sponsored by Organizations Other than Pharmaceutical Manufacturers

Many seniors without drug coverage continue to pay full retail price at their local pharmacy, and that price can vary widely across outlets. However, most could lower their costs through discount programs offered by retailers, membership organizations, pharmacy benefits managers, and internet pharmacies.[8] These programs offer discounts on prescription drugs from numerous manufacturers, but the level of savings can vary widely. Many of these programs are open to seniors regardless of their income.

A wide variety of options are available to consumers, including private discount cards and low-margin retailers. For a $20 annual enrollment fee, AARP's MembeRx Choice boasts average discounts of nearly 20 percent off retail prices. Major retail pharmacy chains like CVS also sponsor drug

discount programs. CVS's Health Savings Pass, a program for people age fifty and older, offers discounts on various health services, including prescription drugs. For an annual enrollment fee of $70 per couple, the drug discounts range from 5 to 50 percent off retail prices when no insurance is applied. Individuals can generally obtain even greater savings filling prescriptions through mail-order pharmacies than they could at retail outlets. Drugstore.com, an internet pharmacy that provides mail-order service, advertises average savings as high as 30 percent. Mail-order programs are widely available.

Senior Discount Card Programs Sponsored by Pharmaceutical Manufacturers

Most of the major pharmaceutical companies have sponsored senior discount programs in recent years to help low-income seniors without prescription drug coverage afford their medicines. Enrollment in these programs is typically free. Seniors who qualify for discount card programs can obtain sizable discounts on drugs manufactured by the card sponsor. For example, the GlaxoSmithKline Orange Card entitles eligible seniors to discounts on the order of 30 to 40 percent off retail prices for many GSK drugs, like the diabetes drug Avandia and the depression medication Paxil.

While the specific eligibility criteria vary among cards, the programs target individuals who are eligible for or enrolled in Medicare and have no prescription drug coverage, public or private. Medicare beneficiaries receiving prescription drug coverage through Medicaid, therefore, are excluded from these programs. The maximum incomes to qualify are generally 200 or 300 percent of poverty, a design that helps a segment of the elderly population financially strained by prescription drug costs but not covered by Medicaid.

The first senior discount card programs were launched in 2002 to help low-income seniors access their medicines until the Medicare program was expanded to cover prescription drugs. Consequently, when Part D begins in 2006, these programs no longer will be in play.

There are two models of drug discount card programs for seniors. One employs discounts off retail prices; the other charges a flat fee for a month's supply of a drug. See table 1 for program details on several discount cards. For both schemes, the price breaks apply only to drugs manufactured by the card sponsor. Under the first type of program, average discounts of up to 40 percent are extended to those eligible for Medicare with incomes as high as $30,000 for an individual (approximately 300 percent of the federal poverty line). The second type of program offers a month's supply of a medicine for a small administrative fee of $15 or less. These programs are typically offered only to individuals with incomes up to 200 percent of poverty.

Under both program models, pharmaceutical manufacturers partner directly with pharmacies to reimburse the discounts. Therefore, not all pharmacies necessarily participate, and the size of the discounts can vary among outlets based on the pharmacy's markup.

Discount card programs strive to be simple and accessible for seniors that qualify. Separate applications must be submitted for each program, but they can be fully completed by the patient and do not require physician approval. Forms are generally available at pharmacies, physician's offices, and company websites. Once seniors are enrolled, they simply present their discount card at the drugstore to receive the discount.

The Percentage Discount Cards. The first senior discount card programs were sponsored by individual pharmaceutical companies and covered only their own products. The only program that covers the products of several companies is the Together Rx card, formed in June 2002 by a coalition of drug manufacturers. The Together Rx card is jointly sponsored by seven pharmaceutical companies: Abbott, AstraZeneca, Aventis, Bristol-Myers Squibb, GlaxoSmithKline, Johnson &

TABLE 1
VARIOUS SENIOR DISCOUNT CARD PROGRAMS

	GlaxoSmithKline Orange Card	Novartis Care Card	Together Rx (7 companies)	Pfizer Share Card	LillyAnswers Card
Eligibility	Medicare eligibles; Income <$30,000 individual, $40,000 couple (~320% poverty); No drug coverage	Medicare eligibles; Income <$28,000 individual, $38,000 couple (~300% poverty); No drug coverage	Medicare eligibles; Income <$28,000 individual, $38,000 couple (~300% poverty); No drug coverage	Medicare eligibles; Income <$18,000 individual, $24,000 couple (~200% poverty); No drug coverage	Medicare eligibles; Income <$18,000 individual, $24,000 couple (~200% poverty); No drug coverage
Discount/ Fee	Discount: 25% off wholesale prices	Discount: 25% off wholesale prices	Discount: Each company sets discounts above a minimum 15% off wholesale prices	Fee: $15 for one 30-day supply	Fee: $12 for one 30-day supply
Scope of Coverage	All GSK drugs	All Novartis drugs	>170 drugs manufactured by participating companies	All Pfizer drugs	All Lilly drugs
Comments	GSK also part of Together Rx	Novartis also part of Together Rx			

SOURCE: Pharmaceutical Research and Manufacturers of America, "Prescription Drug Discount Card Programs for Seniors," November 2003.

Johnson (and its subsidiaries Janssen and OrthoMcNeil), and Novartis. The program currently offers discounts on more than 170 prescription drugs. To avoid antitrust violations, each company individually sets the discounts off the wholesale prices of its products. Actual savings to consumers are expected to average 20 to 40 percent off retail prices and could be as high as 70 percent for some drugs. Above a certain minimum discount, firms can vary the level of savings they offer at any time. Nearly all retail pharmacies participate in the program. Discounts under Together Rx are also available for some generic drugs. In September 2003, program membership surpassed 1 million.

The Flat Fee Cards. Discount cards that offer drugs for a flat fee make their own drugs available to qualifying patients for an extremely modest monthly sum: $12 for Lilly medicines and $15 for Pfizer drugs. Such cards are considered by the sponsors to be patient assistance programs rather than discount cards. However, they differ from the broader class of PAPs in several important ways: They do not require a physician's approval, prescriptions are typically filled by retail pharmacies, and they are limited to Medicare-eligible patients.

Medicare enrollees with incomes as high as $18,000 for an individual (about twice the federal poverty level) are eligible for the Pfizer and Lilly cards. The Pfizer Share Card was launched in January 2002 and has enrolled more than half a million patients to date. LillyAnswers was introduced in April 2002, and several hundred-thousand people have benefited from the program since then.

Patient Assistance Programs Sponsored by Pharmaceutical Manufacturers

All pharmaceutical companies have long-standing programs that offer their drugs free of charge to individuals of any age without the means to pay for them. Member companies of the Pharmaceutical Research and Manufacturers of America (PhRMA) alone enrolled 6.2 million people in their patient assistance programs in 2003. They donated more than 17 million prescriptions valued at $3.3 billion. However, these programs are usually difficult to access, and some eligible seniors may prefer to forego the potential savings for a simpler alternative.

Pharmaceutical companies have traditionally strived to ensure that their medicines reach patients that could not otherwise afford them. As health care has grown increasingly reliant on pharmaceuticals, charitable efforts to assure access to them have evolved, too. While some PAPs date back to the 1950s, most were formalized in recent decades.

Each pharmaceutical company has its own standards in place to qualify individuals for its patient assistance program. To be eligible for a PAP, an individual cannot have any prescription drug coverage or must have already exhausted his drug benefit. Income limits to qualify vary among programs but are generally lower than they are for senior discount card programs. Part of the application for patient assistance programs usually must be completed by the patient's physician. Most often, the prescription is then mailed to the physician, who dispenses it to the patient. Other times, although far less frequently, the medicines are mailed directly to the patient or the patient is given a voucher to present at the pharmacy.

While PAPs are extremely generous, they are often faulted for being too cumbersome to access. Not only does each pharmaceutical company have a separate application, but each prescription refill requires a new application. Particularly for low-income clinics that rely on these programs, the process can be difficult to keep up with. This may have made sense in an earlier era when few patients had chronic need for high-cost medications, but that is no longer the case, in large part due to the development of successful new drugs. The enrollment process for PAPs by and large has not evolved to accommodate the increased need for such programs. However, the Merck company, in an effort to facilitate access to its program, has extended the enrollment period between applications to one year.

Efforts to increase public awareness of and access to patient assistance programs are underway. PhRMA recently launched an interactive website, www.helpingpatients.org, to help patients identify the programs for which they could qualify. After responding to a few brief questions about income, prescription drug needs, and insurance status, individuals are directed to the appropriate program websites and application forms. PhRMA is also working to streamline the application process with a dynamic form available on its website. Patients submit information in a general questionnaire, which is used to fill out the individual PAP applications of forty participating companies. The physician then completes the prescription information, and the patient submits the application to the program sponsor. While the dynamic form facilitates applying to *some* PAPs, not all program applications can be accessed by it. Moreover, the website itself may be challenging for seniors to navigate.

The pharmaceutical industry is also working to promote the visibility of its patient assistance programs so that more individuals that qualify actually enroll. Campaigns to publicize the programs are underway in several states.

State Pharmacy Assistance Programs

States also sponsor programs to help seniors afford prescription medicines. Twenty-nine states currently administer a state pharmacy assistance program (SPAP), and nine more have legislated their creation (see table 2). All SPAPs cover the elderly, and about half extend the benefit to the under-sixty-five disabled population as well. The income thresholds to qualify vary widely, from 100 percent of poverty in

TABLE 2
STATE PHARMACY ASSISTANCE PROGRAMS

State	Year Created	Type of Program	Pharmacy Plus Waiver
Arizona	2003	Discount	
California	1999	Discount	
Connecticut	1986	Subsidy	
Delaware	1981	Subsidy	
Florida	2000	Subsidy & Discount	Yes
Illinois	1985	Subsidy & Discount	Yes
Indiana	2000	Subsidy	
Iowa	2002	Discount	
Kansas	2000	Subsidy	
Maine	2000	Subsidy & Discount	
Maryland	1979	Subsidy & Discount	
Massachusetts	1996	Subsidy	
Michigan	1988	Subsidy	
Minnesota	1999	Subsidy	
Missouri	1999	Subsidy	
Nevada	1999	Subsidy	
New Hampshire	2000	Discount	
New Jersey	1975	Subsidy	
New York	1987	Subsidy	
North Carolina	1999	Subsidy	
Ohio	2002	Discount	
Oregon	2003	Discount	
Pennsylvania	1984	Subsidy	
Rhode Island	1985	Subsidy	
South Carolina	2000	Subsidy	Yes
Vermont	1996	Subsidy	
West Virginia	2000	Discount	
Wisconsin	2001	Subsidy	Yes
Wyoming	1988	Subsidy	

SOURCE: National Health Policy Forum, "The Basics: Medicare Prescription Drug Discount Card Programs," George Washington University, April 26, 2004, available at www.nhpf.org/pdfs_basics/Basics_DrugDiscountCard.pdf.

Louisiana to as high as 500 percent in Massachusetts. Some states offer the benefit to all income levels but adjust enrollee cost sharing according to an individual's means. Other states modify the eligibility requirements for patients with catastrophic drug spending. Most do not consider a person's assets in determining eligibility.

There is generally no enrollment fee for SPAPs, but all require some degree of patient cost sharing. Like senior discount card programs sponsored by pharmaceutical companies, state pharmacy assistance programs can follow two models. In most cases, the state subsidizes the cost of the medicine and the enrollee contributes a modest copayment, between $1 and $30. SPAPs can also function as discount programs, where enrollees obtain better drug prices through discount cards or the formation of purchasing pools. Some state programs employ both direct subsidies and discounts. Under both models, states negotiate directly with drug manufacturers for better deals on the drugs that seniors use most often. State programs cover most prescription drugs, but some lifestyle drugs and over-the-counter medications are excluded.

While state pharmacy assistance programs are typically supported by state budgets, four states receive federal Medicaid funds as well. Pharmacy Plus Waivers allow states to extend Medicaid prescription drug coverage to low-income seniors not otherwise eligible for Medicaid. Federal funds are used to insure SPAP enrollees with incomes below 200 percent of poverty.

The Medicare Prescription Drug Discount Card Program

The Medicare prescription drug discount card program offers immediate assistance to seniors and disabled Medicare beneficiaries until the full drug benefit goes into effect in January 2006. According to a recent U.S. Department of Health and Human Services study, prices for brand-name drugs under the discount card program could range from 10 to 17 percent below retail, about as good as other widely available discount programs.[9] Many Medicare drug discount cards also offer lower-cost mail-order service. Although the Medicare drug discount card is available to most Medicare beneficiaries, it is of greatest value to those who have no other source of prescription drug coverage regardless of their income.

Low-income seniors who enroll in a Medicare drug discount card program are eligible for a subsidy of $600 a year to help with their drug purchases if they have no other drug coverage. In addition, many of those beneficiaries are also eligible for special low prices offered by pharmaceutical manufacturers through senior drug discount programs and patient assistance programs. The Medicare drug discount card often can enable those eligible to take advantage of such special prices seamlessly, without requiring low-income seniors to juggle several discount cards to get the lowest possible price.

Medicare Drug Discount Cards

Enrollment in the Medicare drug discount card program is voluntary and open to all Medicare beneficiaries except those who have prescription drug coverage through Medicaid. Seniors who decide to enroll must select only one Medicare-approved card, but they also may use other discount cards that have not been endorsed by Medicare. Enrollment began on May 3 and will continue for the remainder of this year. Once beneficiaries have selected a card, they have only one opportunity in late 2004 to switch to another card for 2005. Discounts offered by the program became available June 1.

Medicare discount cards are offered by a wide array of private sponsors, including retail pharmacies, pharmacy benefits managers, and health plans operating under the Medicare Advantage (MA) program. Forty Medicare drug discount cards are available to beneficiaries nationally, and thirty-three other plans operate regionally. In addition, eighty-four discount card plans are available to members of MA plans.

Sponsors may charge an annual enrollment fee up to $30. That fee is waived for beneficiaries with incomes up to 135 percent of the federal poverty level. Most MA plans and five national sponsors offer

discount cards at no charge. Sponsors must assure that beneficiaries have ready access to their prescriptions through bricks-and-mortar pharmacies, and sponsors may also offer mail-order service.

Card sponsors may use formularies, or specific lists of discounted drugs, which are expected to result in deeper discounts for their enrollees. Those formularies must cover 209 categories of the pharmaceuticals most commonly used by Medicare beneficiaries. At least 55 percent of these categories must have a generic equivalent available, and pharmacists are required to notify beneficiaries if a lower-priced generic is available for the prescription they seek to fill. Card sponsors can add or drop drugs from their formularies as long as they keep at least one product in each of the 209 therapeutic categories.

Sponsors can change the discounts available on individual pharmaceuticals, but price increases cannot be arbitrary. Any price increases not reflecting changes in actual costs or price levels prevailing in the market can be rejected by the CMS. Moreover, the card sponsors are constrained by their own self-interest: They want to increase enrollment in their plans next year. Sponsors are likely to offer the full Medicare drug benefit in 2006 and want to retain as many of those beneficiaries as they can over the long term. Arbitrary price increases or changes in the availability of pharmaceuticals would only reduce their future prospects for commercial success.

The beneficiary education campaign mounted by the CMS faced some early difficulties, but most of those problems are easing as information systems mature. The CMS provides information on each Medicare drug discount card, including the prices of pharmaceuticals and their availability at retail locations and by mail order, at www.medicare.gov. That website also provides information about other prescription drug assistance programs that may be available to beneficiaries through state agencies, pharmaceutical companies, and other private organizations. A telephone hotline (1-800-MEDICARE) is also available, although the volume of calls has overwhelmed this system in the first month of the enrollment process.

Transitional Cash Assistance

A key part of the program is a cash subsidy for the cost of prescriptions, available to some low-income beneficiaries in both 2004 and 2005. The $600 subsidy is available only through a Medicare-approved discount card, which functions as a debit card to simplify access to the funds. The federal government also pays the annual enrollment fee for the drug discount cards for those eligible.

Individuals without drug coverage whose incomes are less than 135 percent of the poverty rate qualify for the cash subsidy. For singles, this means those making less than $12,569 per year; for married couples, it means those making less than $16,862 per year. Medicare beneficiaries who are also eligible to receive assistance for prescription drugs through Medicaid, TRICARE for Life,[10] or an employer group health plan cannot receive the cash subsidy.

Medicare beneficiaries eligible for transitional assistance receive the full $600 subsidy for 2004 even though the program did not begin until midyear. Any balance left over from the $600 subsidy at the end of 2004 will be added to the 2005 allocation. This rollover provision could be particularly important for beneficiaries who enroll in the Medicare discount card program late and might not spend their entire subsidy by the end of this year.

Legislators decided that even low-income seniors should pay at least something for their drugs so that they would appreciate the value of the benefit. The new law establishes two categories of recipients for whom assistance will be offered:

- Those with incomes below 100 percent of the poverty rate would pay 5 percent of the cost of their prescriptions until they exhaust their cash subsidy, with the rest deducted from their Medicare account. That amounts to $30 in out-of-pocket payments for a beneficiary spending $600 for prescriptions.
- Those with incomes of 100 percent to 135 percent of the poverty rate would pay 10 percent of the cost until they exhaust their cash subsidy.

That amounts to $60 in out-of-pocket payments for a beneficiary spending $600 for prescriptions.

After the cash subsidy is spent, low-income beneficiaries are liable for the full discounted cost of their prescriptions. However, many beneficiaries can take advantage of deep discounts offered by pharmaceutical manufacturers through their senior discount card programs.

With the implementation of the Medicare discount card program, the special manufacturer-specific discounts are typically limited to seniors with incomes below 200 percent of the federal poverty level. Eligible seniors receiving the cash subsidy qualify for the larger discounts once they have spent the $600. For example, a prescription that retails for $75 might cost a higher-income senior who is not eligible for any special discount $60 a month through a Medicare discount card. The same medication might be obtained by a low-income senior for $15 or less after the beneficiary has exhausted his or her cash subsidy.

Several drug manufacturers contracted with most Medicare discount card sponsors to make their senior discounts available to low-income beneficiaries without having to enroll in a separate discount card program. Other companies adopted different marketing strategies. Pfizer, for example, appears to have contracted exclusively with the United U Share Card to offer its products to eligible beneficiaries for only $15 a month. Sponsors of the Together Rx card and the GSK Orange Card decided not to integrate their discount programs with the Medicare discount card. Instead, seniors have the option of using the Medicare-approved card or an alternative such as Together Rx or the Orange Card to get the greatest savings.

Some low-income seniors also are eligible for no-cost pharmaceuticals through patient assistance programs sponsored by the drug companies. As discussed previously, those programs require a special application process and are available only to people (of any age) who lack the resources to buy necessary medications. They typically distribute pharmaceuticals through physicians' offices rather than through retail pharmacies. Moreover, state pharmacy assistance programs may provide additional support to low-income seniors once the $600 federal subsidy has been spent.

Both the temporary discount card program and the $600 annual subsidy end in 2006, to be replaced by the full Medicare prescription drug benefit program, often called Part D. At that time, seniors can enroll either in one of the new subsidized Medicare Part D prescription drug plans or in a Medicare Advantage plan to receive drug coverage.

Finding the Best Deal

Much of the analysis of the Medicare prescription drug discount card naturally focuses on the size of the discounts that could be available under that program. Most studies compare the price of a thirty-day supply of a drug under the Medicare discount card with some measure of the retail price (perhaps obtained from a local retail pharmacy) or prices available through other discount card programs or internet sites. On the basis of these kinds of studies, some commentators concluded that discounts under the Medicare program are no better than discounts available elsewhere.

Such discount comparisons can be a misleading indicator of the savings available to seniors under the Medicare drug discount card program. The actual value of the new program to an individual over the course of the year depends on other important factors typically overlooked by studies that simply compare the prices of a few top-selling drugs. A senior might be eligible for the $600 cash subsidy depending on his or her income. Even a person who is not eligible for the government's subsidy may qualify for deeper discounts on specific manufacturers' products than found on the Medicare website.

Considering all savings options generally available to seniors, we find that the new Medicare program offers substantial savings to low-income seniors compared to the amount they would spend on their prescriptions at retail prices or through other widely available sources of discounted drugs. A significant portion of those savings is due to the $600 subsidy, but senior discount programs sponsored by pharmaceutical manufacturers that coordinate with the Medicare program also account for a sizeable share of the savings.

Higher-income seniors who do not receive the cash subsidy can also save using a Medicare discount card, depending on their specific prescriptions and whether they are already shopping aggressively for the lowest price. We found significant savings, even compared to the cost of prescriptions available from AARP and internet pharmacies, for seniors who use only the baseline discounts offered by Medicare cards to all beneficiaries.

The confusion caused by looking only at drug prices and not considering the cost of prescriptions over the year could lead many seniors astray. Critics assert that the Medicare discount card does not offer lower prices than Canadian pharmacies or the cost of drugs to the U.S. Department of Veterans Affairs (VA), at least on branded drugs. While prices for such drugs are generally higher through the Medicare program, that program also provides easier access to pharmaceuticals through thousands of retail pharmacies and other features that add to operating costs. Nonetheless, many low- and moderate-income seniors

TABLE 3
THREE HYPOTHETICAL BENEFICIARIES

	Age	Conditions	Prescription Drugs*
Robert Smith	66	Diabetes	Glucophage
		High blood pressure	metoprolol
		High cholesterol	Zocor
		Erectile dysfunction	Viagra
Mary Jones	74	Congestive heart failure	Lasix
		High blood pressure	metoprolol, Zestril
		High cholesterol	Lipitor
		Osteoarthritis	Vioxx
		Gastric reflux disease	Prevacid
Fred Green	78	Chronic lung disease	albuterol
		Blood clots	Coumadin
		Seasonal allergies	Allegra
		Hypothyroidism	Levoxyl
		Depression	Paxil

SOURCE: Authors' assumptions.

* These prescription drugs make up the "branded" basket of drugs used by our hypothetical seniors. Another set of drugs making greater use of generic substitutes was also considered (the "generic" basket); see the appendix.

without drug coverage could, in fact, save more money under the Medicare discount card program. By taking advantage of privately negotiated discounts and special manufacturers' prices, those seniors would pay much less over the course of the year than they could even with VA and Canadian prices.

Many seniors have a wide choice of Medicare-approved discount cards that offer savings at or very close to their best deal. The beneficiaries we analyzed had between thirteen and twenty Medicare card options within 5 percent of the lowest cost plan as reported on Medicare's website. However, low- and middle-income seniors without other coverage should check to see if pharmaceutical manufacturers' senior discounts are available to them. Under some circumstances, one card could prove to be a much better deal than any other, even if its baseline prices reported on the Medicare website are not the lowest.

There is no universal answer to how much seniors will save by enrolling in the Medicare drug discount card program. Actual savings depend on both what the Medicare card offers and what the individual has already done to reduce the cost of prescriptions. Some seniors prefer the familiarity of the local pharmacy, even though the price is higher than other options. They are likely to find that the Medicare drug card allows them to continue to shop locally at reduced prices. They probably could save more through a Medicare mail-order option or, for that matter, an internet pharmacy, but cost savings may not be their only consideration.

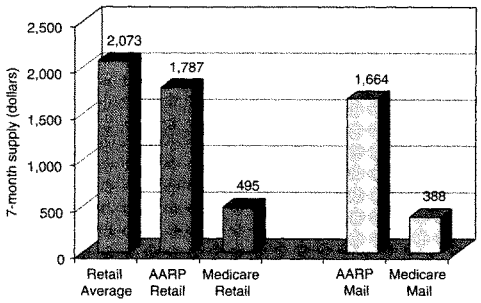
The new program will spur seniors to look more carefully at their options, and some may reconsider the way they currently purchase their prescriptions. Even if they do not enroll in the Medicare card program, some seniors are likely to find other alternatives that will save them money on their prescriptions compared to their current costs.

Three Typical Beneficiaries

To understand the full impact of the new program, we must put ourselves in the place of a typical senior. We developed three hypothetical patient profiles for seniors with arthritis, hypertension, high cholesterol, diabetes, and other health conditions common to an older population (see table 3). For each person, we identified medicines typically prescribed for his or her health conditions and identified generic drugs frequently substituted for brand drugs when appropriate.

Price information was current as of June 1, the first day Medicare beneficiaries could take advantage of discounts using the card. We determined

FIGURE 1
MR. SMITH CAN SAVE 75 PERCENT OVER THE NEXT SEVEN MONTHS



SOURCE: Authors' calculations. Data collected June 1, 2004.

the cost of pharmaceuticals prescribed for each of our beneficiaries under the Medicare discount card program and six other sources of low-priced drugs. Since subsidies and discounts depend on a beneficiary's income, we repeated the exercise for seniors at three different income levels:

- Up to 135 percent of the federal poverty level, no other drug coverage—eligible for the $600 subsidy and special manufacturers' discounts for some drugs.[11]
- Between 135 percent and 200 percent of poverty, no other drug coverage—eligible for special manufacturers' discounts for some drugs.
- Above 200 percent of poverty or any lower-income beneficiary *with* drug coverage—eligible for only the standard discounts reported on the Medicare website.[12]

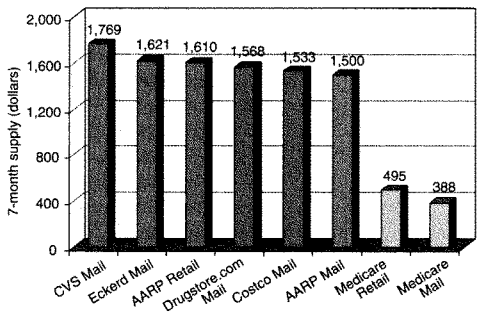
Savings were calculated over the seven months (June through December) that the new Medicare program will be in operation this year. The assumptions made in this study are more fully documented in the appendix.

Savings for Low-Income Seniors. Consider Robert Smith, a sixty-six-year-old man with modestly well-controlled diabetes, high blood pressure and cholesterol, and the need for an occasional Viagra pill. He also takes Glucophage (a branded drug for diabetes), metoprolol (a generic drug for hypertension), and Zocor (a branded drug for cholesterol) on a daily basis.

Mr. Smith is married, lives in Brooklyn, and has a family income of $16,000—just under 135 percent of the poverty level. He is a member of AARP and purchases his drugs through AARP's retail pharmacy program. Although he is eligible for senior discount programs offered by drug manufacturers, he has not applied for those programs. His monthly drug spending, with the AARP discount, comes to just over $255. Between June and December, he will spend $1,787 on prescription drugs. The retail price of those drugs would be even higher without the AARP discount, approximately $2,070 over the next seven months.[13]

Under the Medicare discount card program, Mr. Smith is eligible for the full $600 subsidy as well as special low prices offered by drug manufacturers' senior discount programs through the Medicare cards. For his medications, the best Medicare card option available to him on June 1 was the U Share Prescription Drug Discount Card. (The same Medicare discount card will not necessarily be the best buy for different people, depending on the drugs they take and where they prefer to fill their prescriptions.) Using that card and with all the other subsidies for which he is eligible, Mr. Smith can purchase his medicines at a retail pharmacy for $495 for the remainder

FIGURE 2
MR. SMITH'S BEST DEALS*



SOURCE: Authors' calculations. Data collected June 1, 2004.

* These package prices account for the regular low prices offered by each retailer plus any available manufacturers' discounts.

of this year, or about $70 a month. He could save even more if he purchased his prescriptions by mail order, which would cost about $388 for the seven months (see figure 1).[14]

Mr. Smith stands to save almost 75 percent off the cost of his prescriptions over the rest of this year compared to his current spending using the AARP discount. Just over half the saving, about $690, is the result of the discount prices and the price breaks from the drug company discount programs. The other $600 in savings represents the cash subsidy given to low-income seniors. Ignoring that subsidy and looking only at price discounts clearly understates the value of the program to someone like Mr. Smith.

Could Mr. Smith beat the savings from the Medicare discount card by just taking advantage of manufacturers' senior discount programs and shopping around? That is unlikely. If Mr. Smith were to enroll in those discount programs available to him, his cost through an AARP retail pharmacy would drop to $1,610. If he also switched to AARP's mail-order option for all his prescriptions, his cost would fall to $1,500, somewhat below what he is now paying but certainly not below his $388 cost under the best Medicare mail order service. Other mail order options—including Eckerd, Drugstore.com, and Costco—offer savings similar to AARP's for Mr. Smith (see figure 2).

This result is repeated in the other cases we examined. Table 4 shows the analysis for our three typical seniors using different assumptions about their incomes and eligibility for the $600 subsidy and special manufacturers' discounts. For each senior, we priced two drug baskets (one with mostly branded products, the other with more generics) at retail pharmacies and through mail order. We assumed that each senior takes advantage of all discounts available under both Medicare and private discount plans.

A typical low-income senior might save between half and three-quarters of his or her drug costs for the remainder of this year compared to the next best private alternative. Low-income seniors who are eligible for the cash subsidy almost certainly will save money through the Medicare discount card program compared to other legitimate sources of discounted pharmaceuticals.

Additional savings are possible if the beneficiary is willing to shift some prescriptions to generic formulations or purchase them through mail order rather than at a retail pharmacy. We switched some (but not all) of the branded drugs in our examples to generics. Our low-income seniors purchasing through the Medicare discount card program typically save around 10 percent compared to the cost of prescriptions that were mainly branded drugs. Greater savings are generally possible if more of a beneficiary's prescriptions are generic, although we

TABLE 4
MEDICARE SAVINGS OFF THE BEST PRIVATE DEAL

Low-income senior (at or below 135% of the federal poverty level*)		
"Brand"**	Retail	53–69%
	Mail	60–74%
"Generic"†	Retail	50–78%
	Mail	58–72%
Moderate-income senior (between 135 and 200% FPL)		
"Brand"	Retail	10–34%
	Mail	16–37%
"Generic"	Retail	10–38%
	Mail	16–29%
High-income senior (above 200% FPL)		
"Brand"	Retail	8–13%
	Mail	15–23%
"Generic"	Retail	6–23%
	Mail	14–24%

SOURCE: Authors' calculations. Data collected June 1, 2004.

* In 2004, the FPL is $9,310 for individuals, $12,490 for couples.

** "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

† "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

found some branded products are less expensive than generics if the beneficiary is eligible for an exceptionally generous manufacturer's senior discount program.

Mail order could save between 12 and 31 percent compared to retail purchases through the Medicare card program for our beneficiaries. However, one of our typical seniors would spend more on mail order than on retail purchase. Mail order generally requires that an individual buy a three-month's supply, which can delay when a manufacturer's senior discount goes into effect. The senior discounts apply after the $600 subsidy has been spent, but an individual could meet that limit partway through a three-month mail-order cycle and not immediately capture the discounts for which he is eligible.

Savings for Higher-Income Seniors. Seniors with higher incomes are likely to see modest but real savings under the Medicare drug discount card program, particularly if they have no other coverage for their prescriptions. Moderate-income seniors, with incomes between 135 percent and 200 percent of poverty, are eligible for manufacturers' senior discount programs through Medicare in addition to the baseline discounted prices posted on the Medicare website. In addition, the Together Rx card, the GSK Orange Card, and perhaps others continue to be available outside Medicare to some seniors without coverage.

High-income seniors, with incomes above 200 percent of poverty, can access only the baseline discounts offered by Medicare card sponsors. Discounts from Together Rx and the Orange Card also are available for seniors with incomes up to about 300 percent of poverty who have no insurance coverage for prescriptions. For our analysis, we assume that a high-income senior is eligible for only the baseline discounts under the Medicare-approved card.

Accounting fully for senior discount programs, the typical moderate-income beneficiaries in our analysis could save from 10 to 38 percent under the Medicare discount card program compared to their next-best private alternative. High-income seniors, who would pay the prices shown on the Medicare website for each card option, could save from 6 to 24 percent in our examples. Although those savings may not be viewed by some commentators as large enough, they are nonetheless real savings compared to what higher-income seniors without drug

coverage typically spend, even when they are careful comparison shoppers.

Those seniors can save more if they switch to generics or purchase through mail order under the Medicare discount card program. Moderate-income seniors might see additional savings of 2 to 17 percent by shifting to more generic drugs. Higher-income seniors would also save from that switch, particularly because they do not benefit from special manufacturers' discounts on branded drugs. In our examples, savings ranged from 6 to 16 percent.

Mail order also yielded significant additional savings, ranging from 9 percent to as much as 19 percent compared to retail pharmacy purchases for higher-income seniors. Once again, however, mail order could prove more costly than retail purchases for a moderate-income senior who is eligible for a generous senior discount card program because of the three-month purchasing cycles.

To test whether the baskets of drugs we identified for our typical seniors might give a false indication of savings, we also compared Medicare discount card prices for the ten top-selling pharmaceuticals with prices charged by other well-known discounters.[15] (Those prices were posted on June 5.) Medicare's best price for retail sales undercut AARP's discounted retail price in every case, with savings ranging from 7 to 35 percent. Medicare's best mail-order price was also best, ranging from 5 to 53 percent lower than the mail-order prices offered by five discounters. This confirms that the prices currently posted on the Medicare website are, in fact, highly competitive.

Medicare Card vs. VA and Canada. Senate minority leader Tom Daschle (D-S.Dak.) and his colleagues recently asserted that the new discount card program does not show real savings compared to Canadian pharmacies or the U.S. Department of Veterans Affairs (VA).[16] That statement confuses price with cost to the consumer. Despite higher prices on branded drugs, many seniors could pay less over the year through the Medicare discount card program than with VA or Canadian prices, particularly if they qualify for the $600 subsidy.

Prices for the top-selling branded drugs available through the VA and Canadian pharmacies are substantially lower than Medicare discount card prices. According to price data for May 24 from Families USA, the VA paid between 6 and 69 percent less than the Medicare discount card price (measured as the best price available through retail sales) for the top ten pharmaceuticals.[17] The Canadian prices used by Sen. Daschle were between 27 and 63 percent lower than the Medicare prices reported by Families USA.

Those price comparisons are not completely fair. They do not include generic drugs, which represent about half of pharmaceutical sales in the United States and offer substantial savings. They compare discounted retail prices under Medicare with prices not available at retail pharmacies in the United States. Americans who take advantage of Canadian prices generally purchase by mail order for obvious reasons, and the VA dispenses drugs through a limited number of facilities rather than through thousands of retail pharmacies, as Medicare card sponsors do. Other requirements of the Medicare program, including consumer hotlines and other information for seniors, may not be available through Canadian pharmacies. The VA tightly controls what drugs may be prescribed by their physicians, while there is no such restriction under the Medicare program. These differences add to the cost of the Medicare discount card program, but they also represent added value to seniors.

Low-income beneficiaries eligible for the subsidy and special discounts almost certainly would save more under the Medicare program than they could even at very low Canadian prices. Seven of the top ten drugs are available to those low-income seniors for $15 or less per month after they have spent their $600 subsidy. Even moderate-income seniors would save if they were eligible for those manufacturers' discounts. Higher-income seniors would pay a higher price under Medicare than Canadian or VA prices, but as we have seen, those prices are substantially below prices available through popular discounters in the United States.

Other Evidence of Potential Savings. The pattern of savings to Medicare beneficiaries by enrolling in the new drug discount card program that we found is broadly consistent with other studies, including a preliminary analysis we completed in early May and later studies by the Centers for Medicare and Medicaid Services (CMS) and the Lewin Group. Each of those studies documents the large savings possible for low-income seniors under the new program, with lesser savings available to seniors who are not eligible for the $600 subsidy. Unlike the CMS and Lewin studies, we explicitly account for the additional savings available to low- and moderate-income seniors through manufacturers' senior discount programs.

Our earlier study[18] followed the same three typical beneficiaries but estimated drug spending using prices listed on Medicare and other websites on May 3. More Medicare discount cards report prices on the Medicare website currently, and the prices of many drugs have come down since the first week in May. Savings for prescriptions filled between June and December of this year were calculated by comparing the best price under the Medicare program with the best available alternative outside Medicare. With that metric, savings for seniors below the poverty level ranged from 30 to 70 percent.[19] Savings percentages would have been somewhat higher if we had compared the cost under the Medicare discount card with the cost of prescriptions at full retail price.

A May 6 study by the CMS[20] reports the cost of a thirty-day supply of pharmaceuticals for six hypothetical beneficiaries living in different parts of the country and compares that with an estimate of the average national retail price. Price data were collected May 3. That study finds discounts ranging from 10 to 17 percent below retail, in line with our savings estimates for high-income seniors who are eligible only for the normal discounted prices found on Medicare's website. They found that the mail-order savings ranged from 4 to 13 percent below Drugstore.com or Costco.com for three Medicare-approved cards, but a fourth card charged about 20 percent more. A subsequent CMS analysis published May 24 (using prices from May 19) found savings from Medicare mail-order outlets ranging from 7 to 24 percent.[21]

In a May 19 study,[22] the CMS also looked at the savings possible to low-income seniors between June and December using the discount card and the $600 subsidy. Using prices available on May 17, the study found savings ranging from 11 to 19 percent below the national retail cost when taking only price discounts into consideration. These are somewhat lower prices than captured in the May 6 CMS study. Factoring in the $600 subsidy raises the net savings to eligible seniors to between 37 and 77 percent off the retail cost. Similar large savings are reported in the CMS analysis of twelve commonly prescribed drugs. None of these estimates accounts for additional savings possible through manufacturers' senior discounts, available through many of the Medicare-approved cards.

The Lewin Group[23] published preliminary findings indicating a wide range of savings under the Medicare discount card program, depending on the specific drug prescribed. They found little state-to-state variation in prices. Total savings for twenty-five commonly prescribed drugs ranged from 16 to 24 percent off retail. The study also examines the costs encountered by patients with eleven chronic conditions. Savings from price discounts alone ranged from 13 to 29 percent over a year; accounting for the $600 subsidy, savings ranged from 29 to 92 percent.

Choosing the Right Medicare Discount Card

How can seniors know whether they should enroll in the Medicare prescription drug discount card program? How important is it for seniors to choose their Medicare-approved card carefully?

For at least one group of seniors, the answer to the first question is easy. Those who are eligible for the $600 subsidy can access that money only through a Medicare-approved card. As the previous analysis demonstrates, those seniors stand to save much more than $600 by enrolling in the new Medicare program, and there is no cost to them since the enrollment fee is waived.

Most beneficiaries need information on the costs they will incur under a Medicare discount card

compared to the costs they will pay if they do not enroll. That means a pricing exercise similar to the one we performed in this study for our typical seniors. The exception to this rule is a beneficiary who is a member of a Medicare Advantage plan. Those plans typically integrate drug discounts with insurance coverage for prescriptions. MA plan members are automatically enrolled in their plan's approved prescription discount card program.

Other factors could sway a beneficiary's decision to select one Medicare-approved card over another. Some seniors may find that the lowest cost option does not include their favorite pharmacy, for example. Seniors living in institutional settings may face special requirements (such as the need for certain kinds of packaging) that may limit their choices. However, most beneficiaries gravitate to the lowest-cost plan—and for many, a large number of cards offer roughly equivalent savings.

Limited Price Dispersion. A striking result of our investigation into the cost of prescriptions under the new Medicare program is the large number of approved discount cards that offer prices very close to the best deal possible. This is relevant primarily to higher-income beneficiaries, who are not eligible for manufacturers' senior discount programs, many of which operate through the Medicare discount card. Because high-income seniors get no additional price breaks, the thirty-day or ninety-day supply prices available from the Medicare website represent the actual cost they will incur over those time periods.

We analyzed the baseline prices of Medicare discount cards available to our three typical beneficiaries, as reported on the Medicare website. Between thirteen and twenty Medicare-approved cards were within 5 percent of the cost of the card offering the best deal on retail purchases of prescriptions. Over the course of seven months, a card plan that was 5 percent more expensive would add between $45 and $120 to the cost paid by those beneficiaries. If a beneficiary could tolerate as much as a 10 percent increase in cost, between twenty-two and twenty-eight plans would be feasible for the three people in our examples.

This wide choice of competitive plans might be expected in a heavily urbanized area such as Brooklyn. But the previously mentioned CMS and Lewin studies confirm that the prices for specific pharmaceuticals do not vary much from place to place. We would expect therefore that most beneficiaries have a wide choice of card options that are similarly priced.

The majority of Medicare beneficiaries, who are not eligible for manufacturers' senior discounts, can easily determine from the Medicare website which of the approved discount cards makes the most sense for them. Lower-income beneficiaries must look more carefully.

Access to Manufacturers' Discounts. Seniors with incomes up to 200 percent of the federal poverty level (and in some instances, 300 percent) are eligible for senior discount programs offered by pharmaceutical manufacturers if they have no other coverage for drugs. Many of those special discounts are available directly through the Medicare discount card for seniors receiving the $600 subsidy. Moderate-income beneficiaries submit an additional application, but they too often get the benefit of the extra discount automatically with the use of their card.

There is, however, no general rule of thumb to guide seniors on what could result in very large savings to them. Some manufacturers plan to contract with every Medicare card sponsor to make this special discount available. Others are likely to contract with only a few sponsors. Pfizer, for example, apparently contracts with only one sponsor, United Healthcare's U Share card. At least two senior discount programs, the Together Rx plan and the GSK Orange Card, remain independent of the Medicare program. In addition, some of these programs give substantial discounts on all of a manufacturer's products, while others give discounts on only selected products.

Beneficiaries who are eligible for senior discount programs are provided only general guidance from the Medicare website, indicating whether a manufacturer has contracted with a card sponsor but giving

TABLE 5
THE TOP FIVE MEDICARE DISCOUNT CARD OPTIONS FOR MRS. JONES

Card	Monthly Retail Price*	Seven-Month Cost with Manufacturer Discounts
1. Preferred Prescription Discount Card	$353.95	$1,538.09
2. U Share Prescription Drug Discount Card	$355.94	**$994.79**
3. myPharmaCare	$356.20	$1,543.96
4. EnvisionRx Plus	$357.77	$1,561.62
5. Prescription Discount Card	$358.07	$1,546.07

SOURCE: Authors' calculations.

* Price is for the "branded" basket of drugs (refer to table 3) and applies no special manufacturer discounts or Together Rx prices.

little additional information. Not surprisingly, the website does not calculate prices for beneficiaries that take into account these special discounts. Although those discounts could be substantial and might be made available automatically, a beneficiary would have to call the Medicare-approved card sponsor to know whether that is the case.

The potential importance of selecting the best Medicare discount card is brought into sharp focus by our example of Mrs. Jones, who uses Lipitor to lower her cholesterol. Lipitor is a Pfizer product, so if her income were below 135 percent of poverty, Mrs. Jones would be eligible to purchase that drug for about $15 a month, but only if she enrolls in the U Share card. The Medicare website shows five drug cards available to Mrs. Jones that are nearly equivalent in cost, varying by less than $5 for a month's supply of all her prescriptions (see table 5). The Preferred Prescription Discount Card is the lowest price, at $353.95 for a month's prescriptions filled at a retail pharmacy. The U Share card appears to come in second, at $355.94.

Many seniors would be tempted to go with the lowest-cost card, even if the savings are only a few dollars a month. That would be sensible for higher-income seniors not eligible for special discounts, but that would be a $540 mistake for Mrs. Jones over the next seven months.

It is essential that Medicare beneficiaries find out the details of special discount programs for the drugs they take that may be offered through approved discount cards. As Mrs. Jones's example illustrates, selecting the best card could bring substantial savings compared to the next best alternative.

81

Prospects for Success

The Medicare prescription drug discount card program was developed in remarkably little time. The Centers for Medicare and Medicaid Services published a regulation detailing the requirements of the new program in December, just two days after the Medicare legislation was signed by the president. That sparked a flurry of interest among firms seeking to participate in the program. By January, the CMS had received applications from 104 prospective card sponsors. A few months later, the CMS approved seventy-three discount card plans open to any Medicare beneficiary and another eighty-four plans open to beneficiaries in managed care plans operating in the Medicare Advantage program.

In contrast to this vigorous response from potential card sponsors, Medicare beneficiaries have been slow to enroll in the new discount card program. Initial reports indicated that 2.9 million people were enrolled in the Medicare prescription drug discount card program by the first week in June, far below the 7.4 million the CMS eventually expects to sign up. About 2.3 million of those beneficiaries were automatically enrolled as a result of being a member of a Medicare managed-care plan. Perhaps as few as 600,000 people signed up for a discount card on their own.

Is this an indication that seniors are not ready or not able to make decisions about their health care? Does this mean that competition cannot work even when competitors line up at the door?

The failure is more mundane. People at any age need time and information to adapt to changing circumstances. Congress required that the Medicare discount card program begin operating in only six months. The CMS has met that timetable, but consumer information efforts continue to be developed. Many seniors remain uncertain about the value of the program to them, and uncertainty breeds inertia.

Despite mounting evidence to the contrary, critics remain skeptical that the discount cards offer lower prices than seniors could find elsewhere. They argue that allowing card sponsors to set their own prices rather than having the government negotiate directly with pharmaceutical companies will lead to higher prices and greater cost to beneficiaries and taxpayers alike. Prices offered by card sponsors in early May may have been somewhat disappointing, seeming to give credence to those fears. Since then, better deals have become available to seniors, due at least partly to the entry of more competitive firms seeking to attract a large share of the Medicare market.

Critics also have charged that card sponsors could pull a bait and switch, raising prices and dropping expensive drugs after seniors are locked into plans that they cannot leave until January 2005. Although such changes are permitted, the

companies sponsoring Medicare drug cards are well-established firms that see the discount card program as an entry to the full drug benefit in 2006. Competition and the desire to build a customer base is likely to force prices down and improve customer service, not raise prices and drive beneficiaries away.

The Medicare drug discount card program introduced a new element of competition into a price-controlled government entitlement. The program is an unusual partnership between the federal government and the private sector, with a taxpayer-provided cash subsidy and privately negotiated discounts that together could substantially reduce the cost of prescriptions for millions of seniors. If that were the sole outcome of the program, it would be a runaway success.

There is even greater potential for good in this fledgling program. For the first time, anyone can learn the price of prescription drugs from a national database that is updated weekly. Over 40 million Medicare beneficiaries are now able to compare prices and get the best deal under the discount card program. The database is limited to prices available through Medicare discount card sponsors and does not include retail prices. Even that level of price transparency is unprecedented in the market for health services.

Consumers must know the price of a product before they can get the best value, and that information has been missing in health care until now. There is reason to hope that the Medicare discount card program could be a catalyst for larger changes in the way we buy health care in this country.

Encouraging Enrollment

It should not be surprising to anyone that enrollment in the Medicare drug discount card program has gotten off to a slow start. According to polls taken months after the Medicare provisions had become law, a sizeable fraction of seniors were only dimly aware of the new benefit provisions enacted by Congress. That speaks more to a lack of need rather than a lack of interest in the new program. Most seniors already have some type of prescription drug coverage, and many probably guessed that a discount card program would be of little value to them. Under those circumstances, a reasonable person would not work very hard to find out about the Medicare discount card program.

AARP's experience may have been typical. It reports receiving thousands of inquiries about Medicare drug discount cards in the weeks prior to June 1.[24] Despite that interest, only about 400 people enrolled in AARP's own Medicare-approved card program by the end of May.

The apparent lack of interest in the AARP-sponsored card points to another potential problem: Seniors may believe that they do not need a Medicare-approved card because they already have a private card under a similar corporate name. As we found in our analysis of three typical seniors, that error could cost low-income beneficiaries hundreds of dollars in savings this year.

The information available to beneficiaries from the CMS and other sources has improved greatly over the past several months, and more improvements are forthcoming. However, many beneficiaries are likely to decide whether to enroll, and which Medicare card to select if they do so, using incomplete information.

The Medicare website provides only limited information on manufacturers' senior discount programs that coordinate with many Medicare-approved cards. The card sponsors' websites provide some additional information but often not enough to tell a beneficiary what his actual costs will be with the special discounts. Telephone calls to several card sponsors may be the only way to accurately determine which of several card options is best for a beneficiary.

This problem conceivably could be resolved by collecting massive amounts of additional data from card sponsors and further complicating the way beneficiaries access that information. Most people want less complication, not more.

A newly formed coalition of organizations might hold the solution to this information problem. Chaired by the National Council on Aging, the Access to Benefits Coalition (ABC) is a group of sixty-eight

organizations serving seniors and persons with disabilities. Those organizations include aging and health care organizations (such as AARP and the Catholic Health Association), charities (such as Easter Seals), and disease-specific groups (such as the American Diabetes Association). The ABC has joined with the CMS to encourage low-income beneficiaries to enroll in the Medicare discount card program.

The ABC could become a clearinghouse for consumer-friendly information. In addition to promoting awareness of the new program, the ABC will soon offer on its website a consumer's guide to discount card plans, possibly including a summary rating. Some ABC members also might make recommendations on which card sponsors may offer the best deal to a beneficiary with particular health needs. Even though such advice would not pinpoint the single best option for a specific individual, advice that cuts through the thicket of technical detail would be welcomed by many.

Competition vs. Regulation

The role of private competition in Medicare has been a major point of contention in Congress. The Medicare drug discount card is the latest field on which this battle is being waged. Those who favor a government-run system assert that competition will not hold down costs. On the contrary, Medicare discount cards undercut the prices offered by private competitors from the outset. They also fear that card sponsors could raise prices indiscriminately without direct government controls. That problem is unlikely to materialize because most of the sponsors have a longer-term interest in the success of the Medicare prescription drug program.

Competition and Better Card Options. Skepticism about the effectiveness of competition in keeping down drug costs was heightened by the CMS's release of the first pricing information in late April and early May. The early offers by Medicare-approved card sponsors were not dramatically lower than competitors, prompting federal officials to respond that prices would come down in subsequent weeks. That has been borne out.

We examined the lowest-priced Medicare discount cards (not accounting for any special discounts) available to our typical beneficiaries on May 3 and again on June 1. The number of cards reporting prices on the CMS website increased significantly over that period. For example, our Mrs. Jones of Brooklyn had fourteen Medicare card options for her drug set when the price finder was launched on May 3. A month later, she had thirty-three cards to choose from. The surge of new cards that have become available to seniors has already bred competition and driven down prices. The best Medicare cards for our three Brooklyn seniors in June were on average 3.5 percent lower than their best options in early May.[25]

Seniors are already getting better deals than our first look at prices, one month ago, suggested. This is a result of competition among Medicare drug cards *and* the influx of new plans that offer deeper discounts.

The initial pricing decisions by card sponsors reflected the substantial costs and uncertainty associated with the new Medicare market. Although many sponsors have experience with private discount card programs, the requirements of the Medicare program are more costly and less familiar to them. Greater customer support is necessary, for example, and sponsors must develop secure ways of administering the cash subsidy component of the program. Those requirements add significantly to the cost of operating the card plan. Sponsors may charge an annual enrollment fee (which can be no higher than $30), but that revenue offsets only a small part of the cost. The remainder must be recouped through higher prescription prices.

Uncertainty about how competitors would price their cards also contributed to prescription prices judged by some as too high initially. We should begin to see card sponsors competing for enrollment by more aggressively bidding down prices and offering better customer service (which might simply mean offering more pharmaceuticals at discounted prices). Some consolidation may be

expected as less successful sponsors drop out of the Medicare market after 2004, and their increased market shares may give the remaining plans additional leverage with pharmaceutical companies on the cost of their products.

Bait and Switch. Critics argue that card sponsors could raise prices sharply once beneficiaries have enrolled. Beneficiaries must remain with the discount card plan that they first enroll in for the year, with one opportunity to switch plans for 2005. That could place beneficiaries at a disadvantage if plans change their discounts or drug lists after the open enrollment period.

Few, if any, card sponsors are likely to pursue a bait-and-switch strategy, where they advertise prices that are too good to be true, then raise prices after seniors are locked into the plan. Safeguards built into the program limit price increases to a limited range that reflects increases in the drug's average wholesale price or changes in the card sponsor's cost of operation. In addition, prices are posted on the CMS website, and drugs cannot be dropped from company drug lists without notifying the CMS in advance. The threat of public disclosure can be a significant deterrent to inappropriate business practices.

The risk of bait-and-switch tactics would be greater if drug card sponsors had only a short-term interest in the Medicare program, so that the loss of market share after the first year would be of little consequence. But most, if not all, prospective sponsors of the Medicare discount card are well-established firms with reputations to protect, and the majority of them are considering continued involvement with Medicare through the Part D benefit. For such sponsors, bait-and-switch practices would be bad business, placing them at a competitive disadvantage.

Catalyst for Change

The Medicare prescription drug card program is clearly a work in progress, and much more needs to be done to make the program known and accessible to seniors, especially low-income seniors, who have the most to gain from it. If public- and private-sector outreach and consumer information efforts are successful, perhaps 7 million beneficiaries will receive substantial assistance with their prescription costs. We may well approach that enrollment target by the end of this year.

The discount card program is a significant departure from the way Medicare typically functions. The program is not a health benefit in the traditional sense but an assistance program. It does not guarantee federal payments for health services, but it gives seniors access to lower prices and, for many, some cash assistance. Enrollees in the discount card program have a strong incentive to find the lowest-cost product that works for them, since in fact they are spending their own money. Those without other insurance coverage who are eligible for the $600 subsidy have always had a strong reason to economize on their prescriptions. That has not changed, but now they have more funds to help with their expenses.

The extent of private sector involvement in this program is also a departure from the Medicare norm. Low-income seniors benefit from a federal subsidy and savings from privately negotiated discounts on pharmaceuticals. Perhaps half the benefit that those seniors receive is the result of private actions rather than government expenditures or mandated prices. Already, some evidence suggests that competition among card sponsors will drive down the cost of prescriptions under this program.

The Medicare drug discount card program was designed as a temporary measure to help those who need the help until the full drug benefit becomes available. The full benefit is a more complex and expensive undertaking than the discount card program. Implementing that benefit in only two years is ambitious and perhaps unrealistic.

If more time is needed, Congress may have an option: Extend the discount card program into 2006 and broaden eligibility for the cash subsidy to moderate-income beneficiaries. Some of the money that would have been spent during the first year of a delayed Medicare drug benefit could be used to give more people cash assistance. An extended and

enhanced drug discount program could give the CMS an additional year to implement the more complex drug benefit.

Policymakers are appropriately focusing their attention on how well the Medicare drug discount program will work for seniors. But the impact of this small program could be much wider. Actions that already have been initiated in the drug discount program ultimately could leverage change in the pharmaceutical market as a whole.

The catalyst for that change is the much-maligned price information posted on the Medicare website. Despite its limitations, this database of pharmaceutical prices is a unique resource. Although there are private sources of information on drug prices, that information is closely held. Medicare now provides such information from Medicare card sponsors freely to anyone with access to the internet. That could be the beginning of a broader move toward price transparency in the market for prescription drugs.

Secrecy over prices is not news in health care. Unlike any other item bought and sold in this country, health care products and services are routinely provided to consumers who do not know what they cost. Without knowing the price, the consumer can hardly be expected to purchase wisely.

Price transparency could revolutionize the pharmaceutical industry. Once prices can be compared with little difficulty, consumers inside and outside Medicare will begin to ask whether they are getting their money's worth.

Moreover, Congress will also ask whether the taxpayer is getting *his* money's worth, and therein lies a danger. The price information that can fuel smart shopping by consumers could just as easily be an invitation to the government to fix prices. There is clearly strong sentiment on Capitol Hill and around the country for such a policy, even though the long-term consequences of federal price controls could be less innovation and fewer effective pharmaceuticals to treat the diseases of an aging population.

We are nearing a crossroad: One path leads to a market catering to consumers, the other to a market dominated by bureaucrats. Congress favored a consumer-oriented approach in the Medicare Modernization Act but by only a slim margin. If the Medicare prescription drug discount card program matures successfully, there is reason to hope that Congress will continue down that path.

Appendix

Measuring Prescription Costs and Savings

Savings available to Medicare beneficiaries under the new prescription drug discount card program depend on the drugs they use, how they choose to purchase those drugs, and their income levels. We began by developing clinical profiles for three hypothetical seniors having chronic conditions commonly seen in aging populations (see table A1).

We identified drugs frequently prescribed for each of these patients, as well as generic equivalents where available (see table A2). Since most people with chronic conditions take a mix of brands and generics, we identified a combination of prescriptions that were more heavily weighted toward brands and another combination more heavily weighted to generics.

We tracked the costs each person will incur for their prescriptions from June through December 2004 under the lowest-cost Medicare-approved card and under other well-known sources of discounted pharmaceuticals (see table A3). Price information was current as of June 1, the first day Medicare beneficiaries could take advantage of discounts available under the card program. By necessity, we assumed that those prices would hold throughout the remainder of 2004. However, it is reasonable to expect that drug prices generally move in tandem between the Medicare discount card program and the broader pharmaceutical market.

Information was collected for people living in Brooklyn, New York, but our conclusions generalize to the rest of the country. Pharmaceutical prices offered by a Medicare-approved card sponsor do not seem to vary much from place to place (although prices between sponsors may differ considerably). A

TABLE A1
THREE TYPICAL BENEFICIARIES

Robert Smith, 66 years old	Diabetes, high blood pressure, high cholesterol, erectile dysfunction (ED)
Mary Jones, 74 years old	Congestive heart failure, high blood pressure, high cholesterol, osteoarthritis, and gastric reflux disease
Fred Green, 78 years old	Chronic lung disease, a history of blood clots in his legs, seasonal allergies, hypothyroidism, and depression

SOURCE: Authors' assumptions.

NOTE: All three patients live in Brooklyn (zip code 11201). Because of the large number of available retail pharmacies, a 1-mile search radius was used in the price finder on www.medicare.gov.

TABLE A2
PRESCRIPTION DRUGS USED BY OUR BENEFICIARIES

Mr. Smith	
"Brand"*	Glucophage 500 mg (2/day†), metoprolol 50 mg (2/day), Zocor 40 mg, Viagra 50 mg (8/month)
"Generic"**	metformin 500 mg (2/day), metoprolol 50 mg (2/day), Zocor 40 mg, Viagra 50 mg (8/month)
Mrs. Jones	
"Brand"	Lasix 40 mg (2/day), metoprolol 50 mg (2/day), Zestril 40 mg, Lipitor 20 mg, Vioxx 12.5 mg, Prevacid 30 mg
"Generic"	furosemide 40 mg (2/day), metoprolol 50 mg (2/day), lisinopril 40 mg, Lipitor 20 mg, Vioxx 12.5 mg, Prevacid 30 mg
Mr. Green	
"Brand"	albuterol 95 mcg (1 vial/month), Coumadin 2.5 mg, Allegra 180 mg, Levoxyl 125 mcg, Paxil 40 mg
"Generic"	albuterol 95 mcg (1 vial/month), warfarin 2.5 mg, Allegra 180 mg, Levoxyl 125 mcg, Paxil 40 mg

SOURCE: Authors' assumptions.

* "Brand" means branded drugs are generally included over generic alternatives.

** "Generic" means generic alternatives are generally substituted where they are available.

† Standard is 1 tablet per day; exceptions noted.

recent analysis by the CMS suggests that prescription prices may be fairly consistent in different regions of the country.[26]

Low-income seniors have more opportunities to save under the Medicare drug discount card than higher-income people (see table A4). Everyone is eligible for the baseline discounts negotiated by card sponsors and posted on the Medicare website.[27] Additional discounts on some manufacturers' drugs may be available through the Medicare card program to beneficiaries with incomes up to 200 percent of poverty. Not all Medicare cards offer the same manufacturers' discounts, and some manufacturers' senior discount cards (such as Together Rx, which offers discounts to people with incomes to 300 percent of poverty) remain available outside the Medicare program.

The amount of extra savings from manufacturers' senior discounts depends on the specific drugs prescribed for the individual and his or her income level. Beneficiaries eligible for the $600 subsidy must generally spend that amount before receiving the larger discount. Since they have received a government grant, these beneficiaries are no worse off than moderate-income seniors who are eligible for only the manufacturers' senior discounts.

We identified nine prescription drugs for our three typical beneficiaries that could be obtained using these special discounts (see table A5). Note that Pfizer is phasing out its Pfizer Share Card but extending those discounts to beneficiaries enrolling in United Healthcare's U Share discount card. Where applicable, we attributed those same manufacturers' discounts to purchases made through non-Medicare sources of discounted pharmaceuticals.

We did not consider additional savings that might be available to some seniors through patient assistance programs operated by pharmaceutical manufacturers and some states. Manufacturers' PAPs are charity programs that donate drugs to needy patients at no cost to them. These programs do not operate in the same way as the discounts available through the Medicare discount card, and they must be applied for outside the Medicare program. State PAPs are not available nationally and could not be incorporated into our analysis. However, PAPs can be an important source of savings for Medicare beneficiaries who are eligible for them.

New information required one significant change between our May analysis[28] and the current study. In the earlier study, we assumed that Merck offered a senior discount card program similar to that of Pfizer and other companies. As with the

TABLE A3
PRESCRIPTION DRUG DISCOUNTERS

Membership Organization	AARP—retail and mail order
Pharmacy Chains	CVS, Eckerd's*—mail order only
General Merchandiser	Costco—mail order only
Internet Pharmacy	Drugstore.com—mail order only

SOURCE: Authors' assumptions.

* Our analysis of prices on May 3 included Walgreen's pharmacy. However, we were unable to capture Walgreen prices in our June 1 price survey because its website was not functioning that day.

other senior discounts, we applied the generous terms of the Merck program to AARP and the other discount purchasing options outside Medicare. We subsequently found that the Merck program operates as a patient assistance program, requiring a physician's approval and delivering the product directly to the physician's office or to the patient's home rather than through a retail pharmacy. Since we do not attempt to incorporate the savings possible through PAPs in this study, we no longer apply the Merck PAP terms to non-Medicare discount purchasing options. However, Merck has modified its program for low-income Medicare beneficiaries who enroll in the Medicare discount card program, allowing them to purchase their prescriptions at retail pharmacies (who may charge a small fee). Thus, the Merck program operates within the Medicare discount card program like other companies' senior discount programs. For that reason, we continue to apply Merck's terms to eligible beneficiaries in the Medicare card program. That has the effect of raising the savings possible through the Medicare program compared to other alternatives.

One point of comparison—the cost of prescriptions at full retail price—is difficult to measure with any precision. Retail prices are generally not available. Discounts offered by pharmaceutical companies, pharmacies, membership organizations, and other sources are often couched in terms of reductions from the average manufacturer's price (AMP) rather than the retail price. The retail price might vary considerably from the AMP, depending on what discounts the retail pharmacy itself can negotiate with pharmaceutical manufacturers and on the local retailer's markup.

The CMS has used a proprietary database from IMS Health to estimate the national retail cost of a thirty-day supply of certain commonly prescribed drugs for six beneficiaries.[29] We calculated the cost of those same drugs available from the AARP retail discount program and computed the average discount over the six people to be 16 percent. The measure used in our study for the retail cost of drugs is simply the AARP price increased by 16 percent. This is, at best, a crude approximation.

The cost of each basket of prescriptions for our three typical seniors under the Medicare discount card and the best private alternative is presented in tables A6–A8. We repeated the pricing exercise for seniors at three income levels, accounting for all subsidies and discounts normally available to seniors through Medicare or private vendors. As previously discussed, the Medicare approved card offering the best deal varies from patient to patient; that is also true for the best private alternative.

TABLE A4
SAVINGS AVAILABLE UNDER MEDICARE DISCOUNT CARD BY INCOME LEVEL

Income	$600 Subsidy	Baseline Discounts under Medicare Card	Manufacturers' Senior Discounts	Mail Order
Low income: <135% federal poverty level ($12,569 individual/ $16,862 couple)	X	X	X	X
Moderate income: Between 135% and 200% FPL		X	X	X
High income: >200% FPL ($18,620 individual/ $24,980 couple)		X		X

SOURCE: Authors' analysis.

TABLE A5
MANUFACTURERS' SENIOR DISCOUNTS AVAILABLE TO LOW-INCOME BENEFICIARIES IN THE STUDY

	Discounts Offered *through* Medicare Card Sponsors	Contracts with Medicare Card Sponsors (no.)	Discounts Offered *outside* Medicare Card
Mr. Smith			
Zocor, Merck	$15/mo. after $600 subsidy exhausted*	23	
Viagra, Pfizer	$15/mo. after $600 subsidy exhausted *only under U Share card*	1	Phase-out: $15/mo. for June, July, and August only
Mrs. Jones			
Lasix, Aventis	–	N/A	$18/mo. under Together Rx**
Zestril, AstraZeneca	$15/mo. after $600 subsidy exhausted†	7	
Lipitor, Pfizer	$15/mo. after $600 subsidy exhausted *only under U Share card*	1	Phase-out: $15/mo. for June, July, and August only
Vioxx, Merck	$15/mo. after $600 subsidy exhausted	23	
Mr. Green			
Coumadin, Bristol-Myers Squibb	–	N/A	$20/mo. under Together Rx
Allegra, Aventis	–	N/A	$65/mo. under Together Rx
Paxil, Glaxo-SmithKline	–	N/A	$74/mo. under Together Rx

SOURCE: Communications with pharmaceutical companies.

NOTE: Many manufacturers of branded drugs offer senior discount programs, but generic manufacturers do not.

* Merck provides drugs at no cost. Pharmacies may charge a fee, assumed to be $15 but could be lower. Outside of the Medicare program, Merck offers only a patient-assistance program.

** Together Rx will remain an independent option, but many of its sponsors are negotiating contracts with Medicare card sponsors.

† AstraZeneca has contracted with the U Share card to offer its products to low-income seniors for free or at low cost, here assumed to be $15.

TABLE A6
HOW MUCH CAN LOW-INCOME SENIORS SAVE ON A SEVEN-MONTH SUPPLY OF THEIR MEDICINES?
Assume incomes are below 135% of the federal poverty level.

	Medicare's Best Deal		Best Private Deal		Percentage Savings	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$494.66	$387.54	$1,609.62	$1,499.77	69%	74%
"Generic"**	$311.68	$369.02	$1,407.10	$1,306.85	78%	72%
Mrs. Jones						
"Brand"	$994.79	$876.80	$2,280.13	$2,218.75	56%	60%
"Generic"	$970.11	$788.33	$1,952.26	$1,867.11	50%	58%
Mr. Green						
"Brand"	$622.91	$450.62	$1,318.85	$1,217.31	53%	63%
"Generic"	$569.36	$390.77	$1,271.84	$1,149.55	55%	66%

SOURCE: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

TABLE A7
HOW MUCH CAN MODERATE-INCOME SENIORS SAVE ON A SEVEN-MONTH SUPPLY OF THEIR MEDICINES?
Assume incomes are between 135 and 200% of the federal poverty level.

	Medicare's Best Deal		Best Private Deal		Percentage Savings	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$1,054.61	$947.49	$1,609.62	$1,499.77	34%	37%
"Generic"**	$871.63	$928.97	$1,407.10	$1,306.85	38%	29%
Mrs. Jones						
"Brand"	$1,554.74	$1,436.75	$2,280.13	$2,218.75	32%	35%
"Generic"	$1,530.06	$1,348.28	$1,952.26	$1,867.11	22%	28%
Mr. Green						
"Brand"	$1,192.91	$1,020.62	$1,318.85	$1,217.31	10%	16%
"Generic"	$1,139.36	$960.77	$1,271.84	$1,149.55	10%	16%

SOURCE: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

TABLE A8
HOW MUCH CAN HIGH-INCOME SENIORS SAVE ON A SEVEN-MONTH SUPPLY OF THEIR MEDICINES?
Assume incomes are above 200% of the federal poverty level.

	Medicare's Best Deal		Best Private Deal		Percentage Savings	
	Retail	Mail	Retail	Mail	Retail	Mail
Mr. Smith						
"Brand"*	$1,574.58	$1,321.76	$1,787.48	$1,664.32	12%	21%
"Generic"**	$1,364.93	$1,140.35	$1,584.94	$1,480.01	14%	23%
Mrs. Jones						
"Brand"	$2,460.43	$2,116.73	$2,662.45	$2,477.30	8%	15%
"Generic"	$2,193.17	$1,872.15	$2,326.42	$2,167.62	6%	14%
Mr. Green						
"Brand"	$1,224.23	$990.62	$1,404.66	$1,283.31	13%	23%
"Generic"	$1,027.81	$930.77	$1,333.65	$1,221.99	23%	24%

SOURCE: Authors' calculations. Data collected June 1, 2004.

* "Brand" refers to a basket where branded drugs are generally included over generic alternatives.

** "Generic" refers to a basket where generic alternatives are generally substituted where they are available.

Notes

1. The Medicare prescription drug discount card is available to all Medicare beneficiaries, regardless of age, except for those who receive drug benefits through Medicaid. Temporary cash assistance under the program is available to certain low-income beneficiaries without other drug coverage, also without regard to age. As a shorthand in what follows and when the context is clear, we refer to *seniors* even though the program is available to both seniors and people under age 65 who are eligible for Medicare because of disability.

2. Robert Pear, "Medicare to Monitor Prices in New Drug Plan," *New York Times*, December 11, 2003.

3. Robert Pear, "Drug Discount Cards Give the Elderly Small Savings," *New York Times*, January 4, 2004.

4. Milt Freudenheim, "Drug Discount Card for Elderly May Confuse as Well as Help," *New York Times*, February 6, 2004.

5. Vicki Kemper, "Prescription Drug Law Leaves Seniors Perplexed," *Los Angeles Times*, February 26, 2004.

6. A funded drug discount card is part of the Prescription Drug Security Plan proposed by Joseph Antos and Grace-Marie Turner in 2001. For more information, see www.galen.org/pdrugs.asp?docID=608. See also Joseph Antos and Grace-Marie Turner, "What Congress Should Do about Prescription Drugs for Seniors," *AEI on the Issues*, September 1, 2002, available at www.aei.org/publications/filter.all,pubID.14231/pub_detail.asp.

7. The CBO estimated the net cost of the entire bill at $395 billion over ten years, reflecting other provisions that reduce federal outlays. See Douglas Holtz-Eakin, "Estimating the Cost of the Medicare Modernization Act," testimony before the House Committee on Ways and Means, March 24, 2004, available at www.cbo.gov/showdoc.cfm?index=5252&sequence=0.

8. A good resource on prescription drug assistance programs is the Medicare Rights Center. A listing of programs is available at www.medicarerights.org/rxframeset.html.

9. See Centers for Medicare and Medicaid Services, "Medicare-Approved Drug Discount Cards Provide Drug Prices Significantly below Average Paid by Americans," May 6, 2004, available at www.cms.hhs.gov/media/press/files/rxcard_savings_analysis.pdf.

10. TRICARE for Life is the health insurance program for military retirees and dependents.

11. We do not include manufacturers' or state patient assistance programs in what follows, although those programs can provide substantial additional savings to eligible beneficiaries.

12. Some manufacturers, including those sponsoring the Together Rx card, extend their senior discounts to people with incomes up to 300 percent of poverty. We assume in what follows that high-income seniors are not eligible for any manufacturers' senior discount programs.

13. Retail drug prices generally are not published. We approximated the retail cost Mr. Smith's prescriptions by adding back the estimated 16 percent discount offered by the AARP retail discount program.

14. Note that the out-of-pocket costs for a senior with an income between the federal poverty level and 135 percent of poverty are $30 greater than an individual whose income is below the poverty level. This is the result of having to pay 10 percent of the cost of his drugs until the $600 cash subsidy has been spent, rather than 5 percent if his income were lower.

15. The list of top-selling drugs is from Families USA, *Sticker Shock: Rising Prescription Drug Prices for Seniors*,

June 2004, available at www.familiesusa.org/site/DocServer/Sticker_Shock.pdf?docID=3541.

16. Deborah B. Berry, "Dems Blast Medicare Cards," *Newsday*, June 3, 2004.

17. Authors' calculations based on Families USA, "Price Comparison: The Department of Veterans Affairs and the Medicare Discount Card," June 2, 2004, available at www.familiesusa.org/site/DocServer/Top_20_and_VA_comparison.xls?docID=3601. That document reports seemingly higher percentage savings compared to VA but only because they divided the price difference by the lower VA price.

18. Joseph R. Antos and Grace-Marie Turner, "New Drug Plan: There's More for the Poor," *Wall Street Journal*, May 6, 2004.

19. We made a change in estimating beneficiary savings between our May analysis and the current study, which has the effect of increasing the savings estimates for low-income seniors. See the appendix for more details.

20. CMS, "Medicare-Approved Drug Discount Cards Provide Drug Prices Significantly below Average Paid by Americans," May 6, 2004, available at www.cms.hhs.gov/media/press/files/rxcard_savings_analysis.pdf.

21. CMS, "Medicare-Approved Drug Discount Cards Continue to Show Significant Savings—Including for Mail-Order/Internet Prescriptions," May 24, 2004, available at www.cms.hhs.gov/medicarereform/drugcard/reports/online_comparison_report.pdf.

22. CMS, "Medicare-Approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries," May 19, 2004, available at www.cms.hhs.gov/medicarereform/drugcard/reports/lowincomestudy5-19-04.pdf.

23. The Lewin Group, "New Study on Discount Drug Cards Shows Average Savings Will Top 20 Percent," May 26, 2004, available at www.lewin.com/Spotlights/Features/SF_Medicare_Drug_Discount_Cards.htm.

24. Robert Pear and Milt Freudenheim, "Drug Discounts Beginning Tuesday, but Sign-ups Lag," *New York Times*, June 1, 2004.

25. Interestingly, several of the best cards in June posted substantially higher prices in May, suggesting that they reduced their prices to meet the competition. This calculation compares the retail cost of the branded drug baskets in May and June.

26. See the previously cited CMS report of May 6, 2004.

27. Drug prices on the Medicare website are guaranteed by the sponsor to be available at participating retail pharmacies and mail-order services, but the actual price could be lower. See Mark B. McClellan, "Statement on Improvements to 1-800-MEDICARE and www.medicare.gov," May 20, 2004, available at www.cms.hhs.gov/cmedia/press/release.asp?Counter=1060.

28. Antos and Turner, "New Drug Plan."

29. See the previously cited CMS report of May 6, 2004, p. 3 and table 1.

About the Authors

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute and an adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. His recent research focuses on the economics of health policy, including Medicare reform, health insurance regulation, and the uninsured. Mr. Antos was formerly an assistant director of the Congressional Budget Office, and he held senior positions in the U.S. Department of Health and Human Services, the Office of Management and Budget, and the Council of Economic Advisers. He holds a PhD in economics from the University of Rochester.

Ximena Pinell is a research assistant at the American Enterprise Institute. Her work includes a variety of projects on health system reform, such as the Medicare prescription drug benefit, drug pricing, and importation. Ms. Pinell graduated from Georgetown University in 2003 with a BA in economics. She will enter the School of Medicine at Emory University in Atlanta, Georgia, in the fall of 2005.

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Private Discounts, Public Subsidies

HOW THE MEDICARE PRESCRIPTION DRUG DISCOUNT CARD REALLY WORKS

Critics wasted no time in pronouncing the Medicare prescription drug discount card program a failure. The evidence, however, proves otherwise.

The new Medicare discount card program can help millions of seniors and disabled people save money on their prescriptions. Prices available through Medicare-approved cards are 5–50 percent lower than prices offered by well-known discounters, including AARP, Costco, and Drugstore.com.

The neediest seniors stand to save even more. For them, discounts negotiated by the card sponsors are only part of the story. Low-income seniors without other drug coverage also receive a $600 taxpayer subsidy and special discounts made available by pharmaceutical manufacturers. Between June and December 2004, these beneficiaries could save between one half and three quarters of their prescription cost through this public-private partnership.

Despite the potentially large savings available through Medicare discount cards, initial enrollment was disappointing. That might have been expected: Seniors are unfamiliar with this novel program, and a storm of bad press may have discouraged some seniors from looking into it. This study documents the need for better consumer information, particularly on special discounts offered by pharmaceutical companies that can provide very generous savings to many low-income beneficiaries. The failure to make that information transparent and easy to access must be overcome if this program is to live up to its full potential.

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute and an adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill.

Ximena Pinell is a research assistant at the American Enterprise Institute. Her work includes a variety of projects on health system reform.

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Mr. FIRMAN. Thank you very much.

Our fourth presenter is Julie James, who is a principal in the Washington, DC, consulting firm of Health Policy Alternatives. She joined the firm in 1998 with more than 25 years' experience in health services research, planning and policy. Before joining HPA, she was chief health policy analyst for the Senate Committee on Finance, where she oversaw policy issues, including Medicare and Medicaid.

Thank you. Welcome.

STATEMENT OF JULIE JAMES, PRINCIPAL, HEALTH POLICY ALTERNATIVES

Ms. JAMES. Thanks, Jim.

I guess the advantage of being last is that I just have to say ditto. Our study, the results are just totally consistent with the other studies that were presented today, with one exception. Thank you, Bob. I just did not even realize it until you spoke that we did have one different finding, so it gives me something to talk about.

The Kaiser Family Foundation asked our firm last spring to take a look at the discount card program and its implementation and a little broader than just what the savings are on the various drugs. We were also looking at what kinds of cards were out there, who was sponsoring them, what their enrollment fees were and the whole education and enrollment process and documenting what was happening as it was being implemented.

We have written that, and you all have a copy of the study, so I am not going to go into very much detail there. I would like to say that we did find, as many of you know, that there was kind of a rocky start. It was difficult to get information to the extent that we started tracking prices the first 2 weeks the prices went up on the Website, and we just had to disregard that information, because it was just so unstable.

But we did enter into constant communication with CMS, and they encouraged us every time we found a glitch to let them know about it, and they went to great effort to try to fix those, and I think everything is working much more smoothly now. There is no question that there is information overload when you have that many cards, that many drugs, that many pharmacies. I mean, there is just this unreal amount of information that you can sort through, and I think that the changes they have made in terms of how you now get the information are very helpful to beneficiaries to try to help them sort out and make their choice.

I am just going to make a couple of points, because basically, as I said, "While the numbers are not exactly the same, we all had a little bit different methodology; we all used a little bit different sources; we chose different sets of drugs, although there is a lot of overlap in terms of those that are most commonly prescribed, so we all came at it a little differently, but we all ended up with very, very similar results."

Starting out, though, in terms of the type of card sponsors, we found that across the nation, an average beneficiary, and let me say that our study focuses on the average beneficiary who would not be eligible for transitional assistance, because we knew other people were looking at that and the impact of the $600. We were

looking at the beneficiary who did not have coverage but would not be eligible for the transitional assistance, and we did not look at those who would have the exclusive cards that were being sponsored by the Medicare Advantage plans.

So we were really coming at this in a more narrow way. Anyway, we found that there was a good mix in terms of the sponsors of the cards. The average beneficiary had about 40 cards to choose from, a combination of the national cards and regional cards that would be available to them. We did find in looking underneath the cards that some of them were exactly the same. They had the same list of drugs; they had the same prices; the only thing that was different was a name and perhaps some of the sponsors, and I am sure there are various reasons for that.

But in effect, the real choice, I guess, was a little bit less than the actual number of cards that would be presented to you. In some cases, for example, we found one card—there were two cards, but one of them was only for transitional assistance people, and one of them was for everybody else. Otherwise, the cards were exactly the same, so there was a little bit of overlap.

Just about half of the cards were sponsored by entities that call themselves pharmacy benefit managers or PBMs. The other half, though, was an interesting mix. You had some of the chain drug stores, the retail drug stores that got together and sponsored cards; you have some managed care plans that were sponsoring cards. There was a mix, and there is a chart in the study that outlines what that mix is. So I think it is not just the PBMs out there, but you have got a mix of people coming at it from different ways. For example, because of that mix and where they are coming from, some of these cards would offer mail order, and others do not. Most do, but there are actually some that do not.

Now, in terms of the savings, we concur that we did find that there were savings. The savings that we found, the numbers are a little bit different, because what we used as our point of comparison was a Website that is put out by the attorney general in Maryland for retail prices in Maryland. It is very difficult to find something that you can use as a baseline, and we found this, and that is what we used. I suspect that the prices that are on that Website are a little bit higher than the average retail prices that CMS is using, and that is why our percentage savings are a little bit greater.

We chose a basket of 10 drugs, and we chose seven cards to look at, because it was kind of a difficult process. We had to go through the Website like everybody else to gather this information. We did not have a master data base that was easy to manipulate.

We found overall savings of 19 to 24 percent at the retail level and 27 to 32 percent in mail order for that basket of 10 drugs. However, for any one drug that was in that basket, we found a rate of 8 to 61 percent savings at retail and 23 to 89 percent savings for mail order. Now, 89 percent savings is pretty mindboggling. When you look at those percentages that are so high, those are usually generic products, and that would be for example a retail $10 generic product that then goes down to $1.10. That is the right math, right? I am trying to think of 89.

So at the lower end of the scale would be your brand products. Obviously, these drugs cost more, and your savings percentagewise are going to be less. The generics, which are often under $10, are where you get those huge percentage savings.

We also compared prices to Costco and Drugstore.com and found that in all cases, Costco was higher, Costco mail order. Drugstore.com was very competitive, and actually, their prices fell right in the middle between the highest card and the lowest card. But what we do not know is what Drugstore.com's prices were before the program started, so we do not know to what extent they were actually competing and lowering prices at that point.

We found, and this is where we differ, I think, from what Bob reported, that the choice of card does make a very significant difference. We had four prototype beneficiaries and assigned a different mix of drugs to each of them. Then, we looked to see what the impact is, because obviously, you have to look at your total aggregate savings for the basket of drugs that you take. We had one prototype individual taking four drugs and found that the difference between the highest card and the lowest card—and we looked at all the cards in this case, not just our seven that we were tracking otherwise, and we found that he would pay, our fictitious Mr. Miller, would pay more than twice as much if he chose the highest price card over the lowest price card, and the difference would be between $112 a month versus $235 a month.

Now, for the other three individuals we tested, the difference was not that dramatic, but it was still significant. I think the lowest difference was the difference between $234 and $278. So again, that is a pretty significant difference for that particular basket of drugs. So we found that shopping around and looking at the cards does make a difference.

Finally, we also found—we were interested to see what was happening with prices over time, and we found that they were really pretty stable. There were some changes in the beginning. As I said, "We dropped the first 2 weeks of data, because a lot of those were simply data errors, data entry errors, data reporting errors." They were not price changes. Some of them were probably price changes, but overall, when we tracked some of these drugs over time, we found that they were pretty stable.

So I guess with that, I will wind up, and we can take questions.

[The prepared statement of Ms. James follows:]

THE HENRY J. KAISER FAMILY FOUNDATION

THE MEDICARE R_X DRUG LAW

5-48

MEDICARE DRUG DISCOUNT CARDS: A WORK IN PROGRESS

Prepared for the Henry J. Kaiser Family Foundation

By

HEALTH POLICY ALTERNATIVES, INC.

JULY 2004

TABLE OF CONTENTS

EXECUTIVE SUMMARY i

INTRODUCTION 1

PART I. THE MEDICARE-APPROVED DRUG DISCOUNT CARD PROGRAM: STRUCTURE, OPERATION, AND CURRENT STATUS 2

APPROVED CARD SPONSORS: REQUIREMENTS AND CHARACTERISTICS 2

- Basic Requirements 2
- Card Program Sponsors 3
- Card Program Choices 4
- The Enrollment Process 7
- Enrollment for Transitional Assistance (TA) 8
- Enrollment Fees 9
- Current Enrollment Numbers 9
- Covered Drugs and Formularies 10
- Drug Pricing 13
- Pharmacy Access 14
- Medicare Advantage Plans and the Medicare Discount Card Program 16
- Coordination with State Pharmacy Assistance Programs 17
- Drug Manufacturer Discount Card and Patient Assistance Programs 19

BENEFICIARY OUTREACH, EDUCATION, AND SAFEGUARDS 22

- CMS Education and Outreach 22
- Card Sponsor Education and Marketing 25
- Consumer Protections Against Fraud and Abuse 25

PART II. DISCOUNT CARD PRICING ANALYSIS 28

- Do Medicare-Approved Discount Cards Save Beneficiaries Money Compared with Retail Prices? 30
- Does Choice of Discount Card Make a Difference? 33
- Have Discounted Prices Changed Over Time? 36

CONCLUDING OBSERVATIONS 37

APPENDIX – PRICING ANALYSIS METHODOLOGY 39

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EXECUTIVE SUMMARY

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) adds outpatient prescription drug benefits to the Medicare program, effective January 1, 2006. To assist Medicare beneficiaries with their outpatient prescription drug costs in 2004 and 2005, the MMA authorizes the establishment of the Medicare Discount Card Program as well as a Transitional Assistance (TA) Program for low-income beneficiaries.

According to the Centers for Medicare & Medicaid Services (CMS), about 3.9 million beneficiaries have signed up for a Medicare-approved discount card, including almost 1 million qualifying for TA. Nearly 2.3 million of those enrolling are members of Medicare Advantage (MA) plans who were auto-enrolled in a card offered by their plan. In addition, seven of the 31 states with state pharmacy assistance programs (SPAPs) have arranged to auto-enroll their recipients in a discount card. If the number of beneficiaries who were "auto-enrolled" by SPAPs is taken into account, the number of beneficiaries enrolling to date on their own initiative would likely be less than 1 million.

This report takes a first look at the Medicare Discount Card Program, with an emphasis on issues affecting beneficiaries. Part I of the report provides descriptive information on the requirements and characteristics of approved discount cards, their sponsors, the number of card choices, enrollment fees, covered drugs, drug pricing, pharmacy networks, and initial efforts by CMS, to educate beneficiaries about approved discount cards and the $600 TA credits.

Part II examines prices offered by card sponsors, and considers potential savings for enrollees. This analysis is designed to address several questions. Can beneficiaries who lack drug coverage realize savings by signing up for a discount card? Does choice of card really matter, in terms of monthly costs/savings? Have prices changed since the program was first implemented?

Our pricing analysis shows that some cards do offer good value when compared to full retail prices paid by cash customers. It also indicates that, after an initial period of price instability and unreliability, the drug prices quoted for these cards have remained relatively stable.

CHARACTERISTICS OF DISCOUNT CARD SPONSORS AND PROGRAMS

Card sponsors. Most of the entities that have been approved for card sponsorship are companies that describe themselves as pharmacy benefit managers (PBMs) or firms that perform some or all of the functions of PBMs. Of the 72 originally approved general national and regional card sponsors, 53% can be classified as PBMs. Other sponsors include a variety of businesses that have partnered with entities that have the capacity to manage pharmacy benefits. In addition, 84 MA organizations sponsor discount cards that are available solely to their enrollees ("exclusive cards").

Number and choice of discount cards. In all, 39 general card programs were originally approved by CMS to accept enrollment throughout the U.S. ("general national" cards); an additional 33 general cards were approved that serve one or more states ("general regional" cards). Little variation exists across the nation in the number of general card programs actually available to beneficiaries, ranging from the originally approved 39 to 43 where multiple regional options are available.

The range of real choices, however, is less than meets the eye. Five of the national card programs that were approved never became operational, reducing the number of general card options to 34. Moreover, many of the card programs are either offered by the same sponsor or utilize the same PBM or similar type of entity. When examined for actual variations in programs, drug prices, enrollment fees, and pharmacy networks, some cards appear to be different in name only.

Enrollment fees. Beneficiaries may be charged an annual enrollment fee of up to $30 per year. While most do charge a fee, just over half of the general national card programs (21 of the 39) charge the maximum $30 enrollment fee for 2004, compared to only three of the 33 regional discount card programs.

Drug lists ("formularies"). Formularies are important because they define the list of discounted drugs offered by a given card program. Card sponsors are required to offer a discounted price on at least one drug in each of 209 categories developed by CMS. In addition, sponsors must provide at least one generic drug in 95% of the categories for which a generic is available.

Analyzing the comprehensiveness of the formularies for each of the discount card programs is not easy. The Prescription Drug Assistance Program (PDAP) tool on the medicare.gov website only responds to queries about specific drugs, thereby making it extremely laborious to ascertain the universe of drugs included in any card's formulary. Sponsors vary, moreover, as to how they describe the products available at a discount through their programs. Some programs use adjectives such as "most" or "many" to describe drugs covered by their cards. Others provide beneficiaries with partial lists that contain those drugs that are most frequently prescribed and indicate that a complete list of discounted drugs and prices can be obtained from their toll-free telephone service and mailed upon request. We did find that certain high cost drugs are available from a more limited number of cards.

Drug pricing. A fundamental issue in the discount card program is the extent to which card sponsors are able to negotiate significant savings, and in turn, pass those savings along to consumers. All card programs are required to report the value of any discounts or price concessions to CMS, but they are not required to pass along the full value of discounts to their enrollees. Discount prices available to enrollees may change at any time, although the magnitude of any change is limited. Card programs may offer deeper discounts to certain enrollees based on income, but only some do.

Retail and mail order pharmacy access. Convenient access to prescribed drugs is important to beneficiaries who often have close relationships with their pharmacist or may be unable to travel significant distances to obtain prescriptions. Of the 19 national cards providing information on the size of their pharmacy network, 3 indicate that they have between 30,000 and 39,999 pharmacies, 12 have between 40,000 and 49,999, and 4 have 50,000 or more. Complaints have emerged that some pharmacies listed as participating in specific card programs may not, in fact, be doing so. Whether this is a data error or a failure of card sponsors to monitor network agreements could not be determined. Of the 34 general national card programs actively marketing in June 2004, at least 26 also offer a mail order option.

Other sources of assistance. Many pharmaceutical manufacturers sponsor patient assistance or discount card programs that provide free or discounted drugs to targeted populations. In response to the Medicare discount card program, some of these companies

have entered into agreements with Medicare-approved drug card sponsors to provide deep discounts on some of their drugs to all beneficiaries qualifying for TA after they have used their $600 annual credit. A few drug companies are also offering additional discounts to enrollees with incomes up to 200% of the federal poverty level.

Education and outreach. CMS has relied mainly on an Internet site displaying comparative information on discount card options and a toll-free telephone line with trained customer service representatives who can furnish similar information and mail printed copies of the data on request. Information is also available directly from each card program, although the content varies widely.

However, the sheer volume of relevant data and the complexity of drug pricing can be overwhelming. Despite the government's significant investment in decision support tools, beneficiary frustration and confusion have reportedly continued, and we too found the process far from user friendly. It is important to note, however, that CMS has reduced telephone waiting times and incorporated improvements to the Medicare.gov website that now make it easier and quicker for those who use these tools.

PRICING ANALYSIS

Our pricing analysis provides a preliminary assessment of the value of Medicare discount cards to beneficiaries who would otherwise buy at full retail price. While proponents of the discount card program have found that beneficiaries stand to save significant amounts of money using Medicare-approved cards, program critics have found that beneficiaries could do just as well or better buying their drugs from Drugstore.Com or through Canadian-based internet pharmacies. Because of the obvious benefit of the drug card program to beneficiaries receiving TA, we focused our pricing analysis on savings for Medicare beneficiaries with no prescription drug coverage who would not qualify for TA.

Methods and limitations. We tracked drug pricing on a weekly basis for a set of 10 drugs commonly prescribed for Medicare beneficiaries and seven discount card programs over the period May 10 through June 28, 2004, but ultimately dropped the first two weeks of this period because of concerns about data reliability. The seven card programs chosen were the ones initially offering discounts on all selected drugs at pharmacies in the locations we targeted --an urban and a rural community in Maryland. The card prices were compared to retail prices reported by the Maryland Attorney General's "Prescription Drug Price Finder" in these same communities (as posted through May 31, 2004), and to two companies that offer mail order service to the general public: Costco and Drugstore.com.

We also developed four 'prototype beneficiaries' to assess the relative value of the selected card programs for their retail pharmacy and mail order prices, both in an urban area (Baltimore) and a rural area (Kansas). The basket of drugs for these beneficiaries were developed to test prices on a variety of frequently prescribed brand and generic medications. (See Appendix for a discussion of our methodology.)

It is important to note that our pricing analysis – similar to findings in other recently reported studies – is limited in scope and subject to some uncertainty because researchers are unable to access the full underlying database for the discount card program, and because some of the available data on pricing and drug coverage has been inaccurate, incomplete, or changing.

Do Medicare-Approved Discount Cards Offer Savings for Beneficiaries?

The results of our pricing analysis are consistent with what card program proponents have said: at least some cards do provide savings when compared with the retail prices paid by cash customers. Drugstore.com also compares favorably with some cards for some drugs. We also found that, after an initial period of price instability and unreliability, card prices on the whole have not moved steadily downward, suggesting that competition between cards for enrollees has not resulted in widespread efforts by sponsors to "meet or beat" the prices of other cards.

Based on our review of the prices for 10 of the drugs most commonly used by Medicare beneficiaries, we found:

- All seven of the card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG) as typical retail prices.
- A Medicare beneficiary purchasing at retail one of the 10 drugs sampled would save between 8% and 61% for a drug, with the precise level of savings dependent on the specific drug, card program, and location of the pharmacy.
- Savings on brand products were less in terms of percentages than generics but more in actual dollars. For example, the highest percentages in savings – 61% and 89% -- were for a generic, furosemide, which retails in urban Maryland at $9.04 to $10.89 for a 30-day supply.
- Using mail order provides significantly greater savings for the sample of drugs over the Maryland Attorney General's reported prices, providing savings of 23% to 89%, again depending on the product, the card program, and location, although most cards require the purchase of a 90-day supply rather than a 30-day supply.

Because prices and savings varied widely among the seven card programs for the ten drugs, we also analyzed the total price for the basket of all ten commonly used drugs, recognizing that this particular basket of drugs would not likely be taken by any one Medicare beneficiary.

For the basket of the ten drugs, we found prices for the card programs were:

- 19% to 24% lower than the aggregate of the median prices reported by the Maryland Attorney General for the Baltimore area;
- 17% to 22% less than the Maryland AG prices in a rural area of Maryland; and
- 27% to 32% lower for mail order when compared to the median Baltimore prices. (See Figure ES1 on the following page.)

The savings reported above do not include any savings derived from switching from a brand to a generic equivalent product. It must also be emphasized that -- even in the absence of using a Medicare-approved discount card -- beneficiaries electing to move from a brand to a generic or from retail to mail order would experience significant savings from the Maryland Attorney General prices.

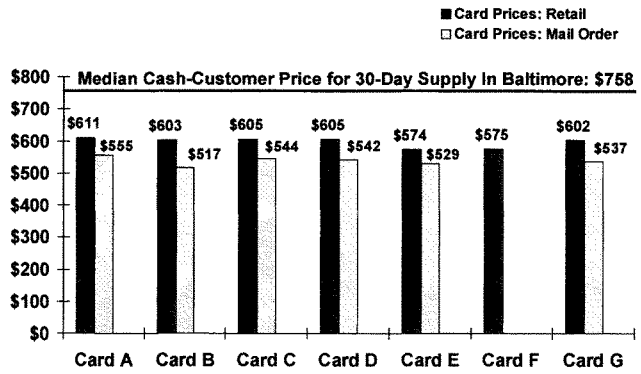
We also tested how these mail order prices compared to two companies that offer mail order to the general public: Costco and Drugstore.com. All six of the seven selected card programs that offered mail order had prices less than those offered by Costco, ranging from 5% less for the card with the highest mail order prices to 11% for the card with the lowest

mail prices. Drugstore.com, however, was competitive with the six cards. The Drugstore.com aggregate price for the ten drugs was 5% higher than the lowest priced card, but 2% less than the highest priced card.

Figure ES1

Do Medicare-Approved Drug Discount Cards Offer Savings?

Comparison Of Medicare-Approved Drug Discount Cards And Cash-Customer Prices



NOTES: Prices for a basket of 10 commonly prescribed drugs for Medicare-age population. Cash-customer prices reported by Maryland Attorney General. For purposes of comparison, mail order prices were adjusted to reflect a 30-day supply. Card F does not offer mail order.

In sum, our analysis shows significant savings for a subset of drugs and a subset of cards, compared to retail drug prices in two areas within one state. However, as others have noted, while these discounts do lower prescription drug costs, beneficiaries continue to face significant drug expenses. We do not know the extent to which the retail prices in Maryland as provided by the Maryland AG are indicative of retail prices in other areas and states. It also should be noted that the prices reported by the card programs on Medicare's website are their highest prices. Some of their participating pharmacies could offer lower prices, and thus produce greater savings for enrollees.

How Much Does Choice Matter?

We also sought to determine how the seven-selected Medicare-approved card programs compared with one another using four different baskets of drugs for four hypothetical beneficiaries. Price results were tracked from Medicare.gov for the seven selected discount card programs for the weeks of May 10 through June 28, 2004, again dropping the first two weeks of this period due to the unreliability of the data. In addition, we determined which of all of the general card program(s) (national or regional) displayed the lowest aggregate price for each of the four beneficiaries' basket of drugs (this almost always turned out to be a card

that was not one of our seven selected programs). For the last week, we also tracked which card program out of all options had the highest aggregate price.

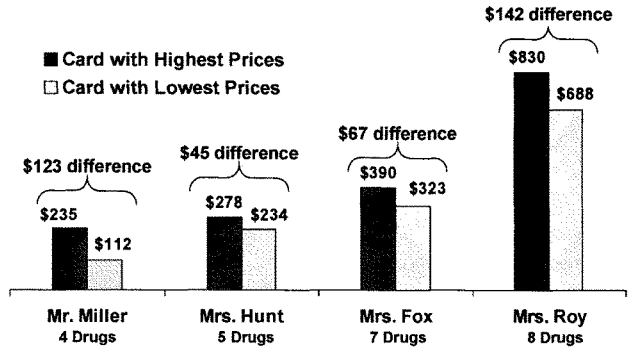
From our analysis we found:

- For three individuals, the retail pharmacy cost of the basket of their drugs for the highest card was 19% to 21% more than the card with the lowest prices, when used at pharmacies in the same area.
- If our four prototype beneficiaries selected the card with the highest prices, over a card with the lowest prices, they would pay between $45 to $142 more per month. For example, Mr. Miller would pay $235 using the card that offered the highest prices, but only $112 using the card that offered the lowest prices, or a difference of $123 for a 30-day supply of his four drugs. (See Figure ES2.)
- An even greater difference existed when the cards with the lowest and highest mail order prices were compared for the four individuals: they would pay $174 to $646 more for a 90-day supply of their drugs.

Figure ES2

Does Choice Of Card Make A Difference?

Difference Between Highest And Lowest Retail Drug Prices Offered By Medicare-Approved Drug Discount Cards (30-Day Supply)



SOURCE: Medicare.gov, June 28, 2004.
NOTES: Retail prices for 30 day supply of each patient's basket of brand and generic drugs (if available) from pharmacies within 2.25 miles of zip code 21211 in Baltimore, MD.

In addition, we looked at the implications for these individuals of substituting generic alternatives when available. Our analysis shows that they would clearly save by electing that option, but again the amount of savings varied by drug, card, zip code, and whether purchased from a retail pharmacy or through mail order.

In short, our analysis illustrates that the choice of a card program may have significant financial implications for beneficiaries, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order). This suggests the importance of careful comparison shopping before enrolling in a specific card program.

Have Discounted Prices Changed Over Time?

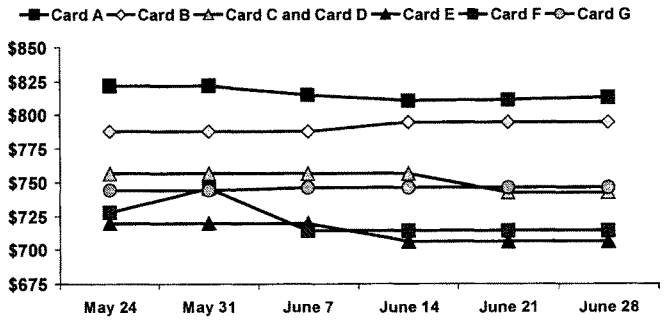
Beneficiary advocates have raised concerns about the potential for card sponsors to increase prices over time once enrollees are "locked-in" to their card choices. On the other hand, CMS has said that prices are likely to fall as a result of competition between the card programs for enrollment. To this point, CMS issued a press release on May 14, 2004 indicating that after the first week of posting prices on the Medicare.gov website, approved card programs had lowered their average discounted prices by approximately 11.5% for brand name drugs and 12.5% for generic drugs in selected zip code areas.

Because of the large amount of data errors we discovered in tracking prices at the beginning of the program (in early-mid May), we were unable to draw any conclusions about price changes during the first several weeks of the program. Over the subsequent six weeks, however (May 24-June 28), our analysis of the selected drugs and selected card programs showed that while there were a few changes up and down for selected drugs and cards, overall prices remained relatively stable. (See Figure ES3.)

Figure ES3

Have Medicare-Approved Drug Discount Card Prices Changed Over Time?

Prices Offered By Seven Selected Medicare-Approved Drug Discount Cards - Illustrative Example for Mrs. Roy



NOTES: Prices reflect mid-point in range of prices reported on Medicare.gov. Card A missing price data for June 7 and June 21, 2004; midpoint estimates used for missing weeks. Card C and Card D reported the same prices for this patient's basket of 8 drugs.

CONCLUDING OBSERVATIONS

Our report documents early experience with the Medicare discount card and TA programs. While we have observed a number of implementation challenges facing CMS and card sponsors, they largely reflect the relatively short time for implementation and the significant administrative and outreach tasks associated with these programs. We note that CMS has continued to make improvements in the quality, reliability, and accessibility of information posted to its website. The sheer volume of information, however, is likely to be overwhelming for many beneficiaries and others assisting them.

Critical to a successful implementation of the discount card program is getting clear and consistent information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Despite a significant investment by CMS in decision support tools, reports of beneficiary frustration and confusion have been widespread. Card sponsor descriptions of key program features, such as drug lists, pharmacy networks, and the availability of additional manufacturer discounts vary, thus making "apple-to-apple" comparisons problematic.

Our effort to determine the value of card programs for 10 commonly prescribed drugs showed that at least some cards do provide value compared to full retail prices. We also found that choice of card program can make a significant difference in the value to an individual beneficiary. The range of pricing differences for our four hypothetical Medicare beneficiaries suggests that card choice can have a significant impact on individuals with limited incomes. In contrast to predictions that market forces would continuously drive prices lower, we did not observe notable changes in reported prices after the initial start up period of the program. It will be interesting to see what happens to prices before the annual open election period in November when enrollees may change enrollment from one card to another.

Overall, the experience to date with implementation of the discount card program suggests some important implications for putting the new Medicare Part D drug benefit in place in 2006. While choice helps to ensure that beneficiaries can find a plan best suited to their individual needs, excessive choice produces confusion and may discourage enrollment. The majority of the 3.9 million enrollees so far have been auto-enrolled by their MA plans or their SPAPs. Direct enrollment by individual beneficiaries has been modest. Moreover, managing beneficiary education is especially challenging and costly for the Medicare population because of the need to use multiple means of disseminating complex information including the availability of trained counselors to provide individual assistance. Although the internet is a useful tool for beneficiary education – and holds great possibilities for increased drug pricing transparency – the need for more accessible "face-to-face" education cannot be overestimated. Most beneficiaries are not now using the internet; even their helpers are often finding the web-based information more perplexing than helpful. Lessons from the card program experience could help to make the transition to a Medicare drug benefit more beneficiary friendly.

INTRODUCTION

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), signed into law on December 8, 2003, adds outpatient prescription drug benefits to the Medicare program, to be effective January 1, 2006. To assist Medicare beneficiaries with their outpatient prescription drug costs in the interim period, 2004-2005, the MMA authorizes the establishment of the Medicare Discount Card Program as well as the Transitional Assistance (TA) Program for low-income beneficiaries. These programs became available to Medicare beneficiaries June 1, 2004.

All Medicare beneficiaries, except for those who receive prescription drug coverage through Medicaid, are eligible to enroll in one of the approved Medicare discount cards. The cards are intended to reduce the price that many Medicare beneficiaries otherwise pay for their prescription drugs either because they have no or very limited drug coverage. Under the TA program, beneficiaries in families with incomes that do not exceed 135% of the federal poverty level ($12,569 for single individuals/$16,862 for couples in 2004), who do not have prescription drug coverage other than Medigap or Medicare Advantage, are eligible to receive $600 for each year, 2004 and 2005, to use through a drug discount card to purchase prescription drugs. Although the card programs may limit the drugs for which they provide discounts, TA may be used to purchase any drug product that falls under the definition of covered drugs for the discount card program.

The Henry J. Kaiser Family Foundation contracted with Health Policy Alternatives, Inc. (HPA) to report on the implementation of the Medicare endorsed discount card program, primarily from the perspective of Medicare beneficiaries. Are the cards providing good value to beneficiaries? What is the federal government doing to promote the program and educate beneficiaries and those who advise them about the program? To what extent is there coordination with other sources of prescription drug assistance for Medicare beneficiaries? Are any major problems developing in the marketplace related to the sale of the discount cards?

As part of this effort, we monitored the implementation of the "Medicare-Approved Drug Discount Card Program" as it officially is called by the Centers for Medicare & Medicaid Services (CMS), the agency with responsibility for implementing the program. This involved monitoring the internet site (www.Medicare.gov) that has been established to help Medicare beneficiaries choose the card program that best meets their needs. (The specific tool on this website that was developed to help beneficiaries compare card options is known as the Prescription Drug Assistance Program tool or PDAP.) We also tracked prices on a set of specific drugs for a subset of the card sponsors. CMS staff were helpful in addressing numerous questions about details of the program and its implementation. In addition, we analyzed program regulations, guidance, and related information; tracked national and trade press stories; and reviewed the many reports and studies evaluating the Medicare discount card program and the prices obtainable using the various card options.

Part I of this report begins with a description of the basic requirements and features of the Medicare-approved Discount Card Program and the cards that are being offered nationally, regionally, and through the Medicare Advantage plans. Following that is a discussion of the role of CMS in promoting it and the additional help available to qualified low-income beneficiaries. We also address how the discount cards interact with State Pharmacy Assistance Programs and manufacturer patient assistance and discount card programs. This

part concludes with a description of the major safeguards against fraud and abuse that have been established through law and regulation.

Part II presents the results of a pricing analysis we conducted of selected card programs for a selected set of prescription drugs. The results of our analysis are consistent with other studies that have reported savings for beneficiaries associated with these cards. We discuss the range of savings that might be achieved by beneficiaries in various circumstances and the factors that affect the magnitude of savings. We also find, however, that for the specific drugs and card programs studied, prices have so far remained relatively stable. This finding contrasts with suggestions by CMS that competition between the card programs would drive prices significantly downward. A detailed discussion of the methodology for the pricing analysis is presented in the Appendix to this report.

PART I. THE MEDICARE-APPROVED DRUG DISCOUNT CARD PROGRAM: STRUCTURE, OPERATION, AND CURRENT STATUS

APPROVED CARD SPONSORS: REQUIREMENTS AND CHARACTERISTICS

Basic Requirements

Under the MMA, Medicare discount cards may only be offered by nongovernmental entities, known as sponsors, with which the government has contracted. The regulations specify that card sponsors must have 3 years of private sector experience in pharmacy benefits management and, at the time of application, operate a pharmacy benefit, discount card, or similar program that serves at least 1 million covered lives. The sponsor must also demonstrate fiscal stability and business integrity, quality customer service and a process for handling complaints.[1]

Medicare discount cards may only be offered by nongovernmental entities known as sponsors. Sponsors can contract to provide cards nationwide (general national cards) or within specific states (general regional cards).

Sponsors can meet these requirements by combining the capabilities of different entities. For example, a group of pharmacies can team up with a pharmacy benefit manager (PBM) or third party administrator (TPA) to sponsor one or more card programs. Sponsors can contract to provide discount cards nationwide (general national cards) or within specific states (general regional cards). A state is the smallest service area permitted. By law, the Secretary is required to contract with at least two different general discount card programs in each state. As discussed below, the minimum number of card program options approved for all fifty states far exceeds this statutory minimum.

Although the MMA permits CMS to limit the number of approved card programs, CMS decided to approve all card programs of qualified applicants. CMS first previewed an initial list of approved discount card program sponsors in late March, 2004, both for the general national and regional cards. It also announced the sponsors for the exclusive cards for Medicare Advantage (MA) health plans.[2] Additional card sponsors were designated for "special endorsement" for nursing home residents and Native Americans.[3]

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[1] *Federal Register*, vol. 68, no. 240, December 15, 2003, p. 69839-69927.

[2] U.S. Department of Health and Human Services, CMS Public Affairs, News Release: *HHS Gives Seal of Approval to Medicare Drug Discount Cards*, March 25, 2004. In testimony to Congress,

At the time of the March announcement, a number of applications from potential card sponsors were still being reviewed by CMS, and some applicants that had been initially turned down by CMS requested reconsideration. In June, 2004, CMS posted on its website a "master list" of approved card sponsors, their product names, service areas, annual enrollment fees, and contact numbers. Summary data on card program totals are presented in Table 1.

Card Program Sponsors

Table 1. Medicare-Approved Drug Discount Card Programs (June 2004)	
General national cards	39
General regional cards	33
Exclusive cards	84
Special endorsement cards	
Long-term care	3
Indian health	3
U.S. territories	4
Source: www.cms.gov., as of June 16, 2004.	

Most of the entities that CMS identifies as general card sponsors are companies that describe themselves as pharmacy benefit managers (PBMs) or use somewhat less specific language such as a pharmacy benefits solutions company. Of the 72 originally approved general national and general regional card sponsors, 53% can be classified as PBMs (see Figure 1 on the following page). Such companies, especially the larger national companies, are well positioned to offer discount cards because they already had in place the administrative infrastructure to run a program, as well as the established processes to obtain drug manufacturer and pharmacy discounts. About 28% of the 72 sponsors identify themselves as third party administrators (TPAs) or pharmacy benefit administrators, commercial discount card companies, various forms of medical technology and information technology companies, and an alliance of retail and chain pharmacies.

The nine managed care organizations that are identified as sponsors of general card programs either operate their own PBM (e.g. Wellpoint) or contract with a PBM or TPA to run the card programs. A few of these programs have partnered with companies that operate

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Michael McMullan of CMS indicated that the 28 general card sponsors were selected out of 55 general applications considered. 27 potential sponsors were rejected based on failing to satisfy completely fundamental requirements of the CMS solicitations. CMS approved 43 of the 44 exclusive card applications. Secretary Thompson was quoted later as saying that those cards that did not pass muster with CMS had problems in one or more areas: insufficient reserves, or the information they gave was not satisfactory; they didn't have the capacity to offer drugs in all 209 categories; they did not have a broad enough network of pharmacies, or (4) their past history with drug discount cards was insufficient. Card applicants had until April to appeal the determination. *Drug Card Management Report,* April 16, 2004.

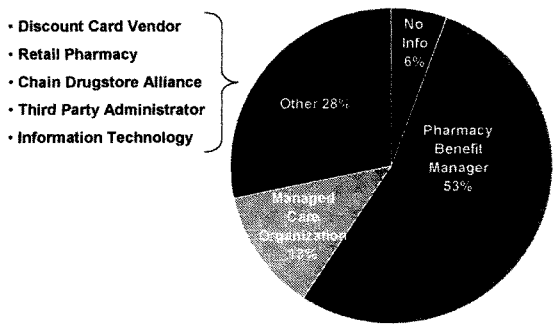
[3] Many nursing homes restrict which pharmacies may supply drugs and pharmacy services to their residents. These pharmacies may or may not participate in the various Medicare-approved discount card programs. CMS has provided a special endorsement to three card programs to serve long-term care pharmacies. Institutionalized beneficiaries eligible for TA will be able to obtain it through these cards. However, these cards are not expected to become operational until later in 2004. The delay is in part due to the need to work out how these endorsed card programs work in states where nursing homes are required to permit their residents to go outside of their nursing homes for their outpatient prescription drugs. (Centers for Medicare and Medicaid Services, Drug Card Sponsor Questions & Answers, Last updated 5/6/2004, p. 57-58 (www.cms.gov); CMS Open Door Conference Call, June 10, 2004.)

commercial drug discount card programs. Wellpoint's partner, for example, Nation's Health, is a discount card vendor.

Figure 1

Types Of Sponsors Of Medicare-Approved Drug Discount Cards

Total = 72 General National and Regional Card Sponsors



SOURCE: CMS, May 21, 2004.

Some of the card program sponsors have disclosed partnerships with other entities, such as grocery stores, insurers, or big box stores. Those that are not partnered with PBMs or TPAs nonetheless mostly have contracts with a PBM or TPA to administer at least some aspects of their card programs.

Card Program Choices

Little variation exists among states in the number of general card programs that were originally approved for sale to beneficiaries. In addition to the 39 card programs that were approved to be marketed nationwide, beneficiaries in all but nine states also have at least one general regional card program serving their area. In five states, beneficiaries have a total of 43 card options.

The large number of card choices is considered by some as the best way to facilitate consumer choice and by others as "daunting, confusing, and downright unattractive to many beneficiaries."

The large number of card choices available to any card-eligible Medicare beneficiaries is viewed by some as the best way to facilitate consumer choice

and by others as "daunting, confusing, and downright unattractive to many beneficiaries."[4] As indicated above, CMS decided to approve card program proposals for all qualified sponsors instead of selectively contracting with a subset of qualified applicants. CMS may have done this to expedite the approval process or possibly to maximize both the choices for beneficiaries and the competition between card programs so as to encourage the best price discounts. But in so doing, CMS may have overly complicated the decision process for beneficiaries.

Moreover, the number of true competitors is fewer than meets the eye. First, not all approved card options are actually available. Some of the general national cards originally listed by CMS are not, in fact, available (and pricing information is not available on the PDAP). This is true for the two Nation's Health cards, two Express Scripts cards, and the Wellpoint Precision Discounts Option B card program. According to CMS, although these programs applied for and received Medicare approval, the sponsors elected not to market them. The subtraction of these five card programs means that 34 general national card options were being actively marketed as of the end of June, 2004.[5]

Second, while it is generally true that a beneficiary has at least the 34 general national card programs to select from and, in most states, some regional card options as well, the real number of options depends on the type of prescriptions needed and the distance the beneficiary is willing to travel to a pharmacy (noting that mail order is an option for many card programs). But even for a given list of commonly prescribed drugs, the number of options is fewer than 34 when looked at in terms of actual variations in programs, drug prices, enrollment fees, and pharmacy access. This is because many of the card programs are either offered by the same sponsor or work through the same PBM or TPA. Although different combinations of partners ("co-branders") may be involved, some cards appear to be different in name only.

The number of true competitors is fewer than meets the eye. Some cards appear to be different in name only.

To illustrate, a beneficiary living in McLean, Virginia seeking prices on three commonly prescribed brand name drugs, would find prices for 33 card programs on the PDAP website (July 5, using the maximum allowed 7-mile pharmacy radius).[6] Two regional cards were included in the list of options. Out of the 33 options listed, six (all connected with AdvancePCS or Caremark which, as of March 2004, are the same company) offered identical price ranges and the same number of pharmacies, and two cards for each of four other associated card sponsors showed the same price ranges and numbers of pharmacies in their networks, bringing the real number of choices

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[4] Senator Max Baucus, U.S. Senate. Committee on Finance, Hearing, *The Medicare Drug Discount Card: Delivering Savings for Participating Beneficiaries*, June 8, 2004.

[5] The five 5 nationwide cards not being actively marketed were sponsored by organizations that have relationships with other cards. Express Scripts is a partner with the Pharmacy Care Alliance, a card that is reportedly drawing relatively high enrollment. Nation's Health is a partner with Wellpoint. Had Express Scripts and Nation's Health marketed their own branded cards, they would have been competing against themselves for enrollment. Whether this is why they withdrew their branded products has not been determined.

[6] The drugs were: Fluoxetine, Nadolol and Celebrex. Information on one card, MedAdvantage Sav-Rx, was listed as not available. As of this date, one of the 34 national general cards – ScriptSave Plus -- had dropped off of the PDAP altogether. According to CMS, it remains, however, a card option. Personal communication with CMS, July 15, 2004.

down to 24. The only obvious differences would be, in some cases, the enrollment fee and, in at least one instance, the availability of a mail order option.[7]

Because so many of the card sponsors use the same PBMs or Third Party Administrators (TPA) to administer all or some aspects of their card programs, we also looked to see whether the presence of the same PBM or TPA resulted in the same prices, list of covered drugs, and pharmacy networks.

Using data on card program TPAs provided by CMS,[8] we found that AdvancePCS provides TPA services to 14 national and regional cards; Anthem is both the sponsor and the TPA for 10 general regional card programs. Express Scripts, which was approved to offer two general cards of its own but decided not to market them, serves as the TPA for seven other general cards. SXC Health Solutions is providing TPA services to seven general card programs. (See Figure 2 on the following page.)

To determine whether common PBMs/TPAs resulted in common card features, including prices and pharmacy networks, we again checked the PDAP for the price of three drugs in one zip code, 62959.[9] For the cards where AdvancePCS is listed as the TPA, we found the same price ranges for the bundle of the three drugs for all five cards available in that zip code (American Prescription Plan, BD Advantage, RxSavings, RxSavings distributed by Mennonite Mutual Aid Association, RxSavings distributed by Reader's Digest). For the cards associated with Express Scripts, however, the price ranges were within $2 of each other (AARP, Pharmacy Care Alliance Option A, and Pharmacy Care Alliance Option B).[10] For Health Trans, we found the same price range for their associated cards, Aetna and ScriptSave Premier. Finally, for SXC Health Solutions, we found the same prices for two cards (Community Care and Criterion), similar prices for two (SXC Health and Public Sector Partners) and one (PBM Plus Senior) that was $50 more for the bundle of the drugs than the others.

Even if cards share the same PBM/TPA, they may charge somewhat different prices, have similar if not the same pharmacy network in a given area, and charge different enrollment fees.

These findings complicate any generalization about PBMs and TPAs. It appears that even if the cards share the same PBM/TPA, they may charge somewhat different prices, have similar if not the same pharmacy network in a given area, and charge different enrollment fees.

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[7] CMS has confirmed that "some cards are the same except for branding." However, "because these are separate cards, going forward they do not necessarily have to stay the same." Personal communication with CMS, June 21, 2004.

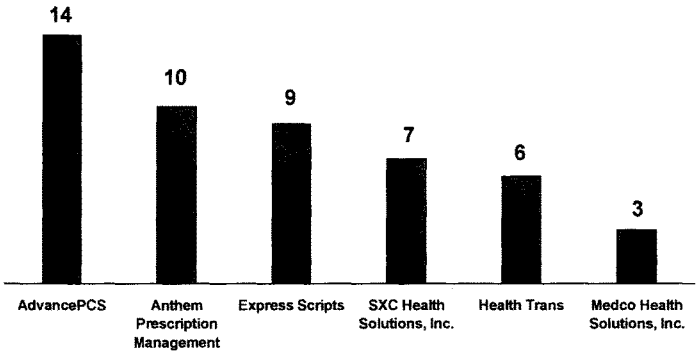
[8] The "TPA" label, used by CMS in its data compilations, may be misleading. In some instances, the organization referred to as a TPA is really a PBM, which may be providing the entire range of cost management and administrative services, including negotiating discounts with drug manufacturers, utilization review, claims processing, and the provision of mail order. Or, it may contract to provide a more narrow range of services, such as claims processing. In some instances, the PBM makes it possible for the card sponsor to offer a mail order option, but the card sponsor handles in-house or through yet another contractor the other functions needed to operate the Medicare-approved card program. In other instances, the entity referred to as a TPA may only be providing claims administration and other administrative services. It may not be negotiating rebates or performing other cost management functions.

[9] Furosemide, Spironolactone, Zocor. The zip code is for Marion, Illinois.

[10] Pharmacy Care Alliance Option B (recommended for people with two or more prescriptions per month) charges one dollar more per prescription than Pharmacy Care Alliance Option A. The enrollment fee for option A is $19.00; for option B, it is $30.

Figure 2

Number Of Medicare-Approved Drug Discount Card Contracts Per Pharmacy Benefit Manager/Third Party Administrator



SOURCE: CMS unpublished data, June 2004.
NOTES: PBMs and TPAs linked to fewer than three sponsors and contracts with exclusive card programs not shown. CMS data on PBM/TPA affiliation missing for six card programs.

The Enrollment Process

Each Medicare discount card program is responsible for collecting enrollment forms from applicants. There are two standard enrollment forms developed by CMS: 1) for general enrollment in a discount card program; and 2) for enrollment in a card program and for eligibility determinations for TA. Card sponsors may use these or their own forms subject to approval by CMS; however, they must accept the standard CMS forms. Implementing regulations from CMS did not provide for standard enrollment forms, but pressure from beneficiary advocates for a uniform application resulted in the release of standard CMS forms.

For beneficiaries who are not applying for TA, the application must be verified by CMS to determine that the applicant is enrolled in Part A and/or Part B of Medicare and does not have drug coverage under a state Medicaid program. The sponsor may also require that the application include the enrollment fee or an authorization for charging a credit card.

General enrollment may be accomplished by mailing or faxing an enrollment form to the card sponsor, or over the Internet, by telephone, or, in at least the case of one card sponsor, at a participating pharmacy. Applicants must be furnished a written explanation if they are not accepted for enrollment and informed of the procedures for reconsideration of an adverse determination. Enrollment is not effective until a card sponsor is notified by CMS that the applicant is a Medicare beneficiary who is not enrolled in Medicaid. Medicaid enrollment

records for each state are matched against card applicants to identify any covered individuals.

Enrollment for Transitional Assistance (TA)

As noted above, the MMA provides a program for TA to Medicare beneficiaries with incomes below certain levels who do not have any other drug coverage (except for Medigap or through MedicareAdvantage plans). Beneficiaries must have annual incomes at or below 135% of the federal poverty line level ($12,569 for single individuals/$16,862 for couples in 2004). Beneficiaries enrolled in any state Medicare Savings Program (MSP)[11] are deemed to meet the income criteria. Eligible individuals are entitled to an annual $600 credit toward the purchase of any covered drug. Beneficiaries must submit a signed application to a card sponsor for TA that attests to their income and states they are not covered by TRICARE, FEHBP, or a private group health insurance plan. The application requires verification by CMS with assistance from the Social Security Administration and the Internal Revenue Service. Balances in the TA credit account may be carried over for an eligible individual's use in the second year. CMS estimates that 7.2 million Medicare beneficiaries will be eligible for the $600 credit in 2004, and that 4.7 million (65%) of those individuals will apply.[12]

Individuals who qualify for TA will receive a $600 credit on their discount card in 2004 regardless of when in 2004 they apply. They will receive another $600 credit in 2005. For those first applying for TA in 2005, the $600 will be prorated based on the calendar quarter in which they apply (e.g., those applying in April will receive $450). The $600 is administered in a manner similar to a debit card. The cost of an enrollee's prescription purchases, less the required coinsurance, is deducted from the $600 until it is exhausted. Individuals with incomes at or below the poverty level are required to pay 5% coinsurance out-of-pocket; other transitional assistance individuals with higher incomes are required to pay 10% insurance.

Beneficiaries who qualify for TA are eligible for a $600 credit on their discount card in 2004 and another $600 credit in 2005.

Medicare beneficiaries who are enrolled in certain state pharmacy assistance programs (SPAPs) may be auto-enrolled in a drug card program, and the SPAP may also apply for TA on behalf of members if all eligibility conditions are satisfied. (Auto-enrollment by SPAPs is discussed in great detail below.) Because low-income Medicare beneficiaries have been slow to enroll in programs offering assistance with Medicare cost-sharing (the so-called Medicare Savings Programs (MSPs), there has been considerable discussion about whether auto-enrollment can be permitted on a broader basis. The MMA includes provisions that "deem" any individual enrolled in a state MSP as meeting the income requirements for TA. However, the statute also requires a signed attestation that the applicant does not have other prohibited government or private health coverage. This requirement has complicated consideration of auto-enrollment since a signed application by the enrollee of his/her legal representatives must be submitted.

Moreover, there are significant challenges in designing an auto-enrollment protocol that is fair to beneficiaries and card sponsors. For example, it is important to preserve the voluntary

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[11] The Medicare Savings Program (MSP) includes Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualified Individuals (QIIs).

[12] Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program; Medicare Prescription Drug Discount Card; Interim Rule and Notice," *Federal Register*, Vol. 68, (December 15, 2003), p. 69891. Referenced hereafter as: *Federal Register,* December 15, 2003.

nature of the program by providing an opportunity to opt out of enrollment or to select a card of the individual's choice within some reasonable time following auto-enrollment. At the same time, it is important not to advantage or disadvantage competing card programs as a result of the auto-enrollment process.

CMS has announced that auto-enrollment is under consideration for beneficiaries who are enrolled in Medicare Savings Programs. It is unlikely that a decision will be announced until there is more information on the number of beneficiaries who have applied for TA on their own. It appears at this juncture, however, that in the absence of auto enrollment, a relatively small number of TA-eligible individuals will actually receive the $600 credits. As noted below (see "Current Enrollment Numbers"), early enrollment figures indicate that not many people are enrolling on their own.

Enrollment Fees

The law allows card sponsors to charge an annual enrollment fee of up to $30 for 2004 and then again for 2005. A free (i.e., no fee) card program is permitted. Any enrollment fee must, however, be uniform across enrollees in a state. The sponsor, and not Medicare, is responsible for collecting it.[13] Almost all nationwide cards charge the same fee across all states; the fees for two of the regional card sponsors vary some by state.[14] Figure 3 on the following page shows the distribution of fees for the general national and regional card programs. The majority of the general national card programs are charging the maximum $30 enrollment fee for 2004 compared to only 3 of the regional card programs.[15]

Current Enrollment Numbers

As of July 12, 3.9 million beneficiaries have enrolled in a card program, including almost 1 million who have qualified for TA. Most have been auto enrolled.

As of July 12, CMS reported that 3.9 million beneficiaries have enrolled in a card program, including almost 1 million who have qualified for TA. However, in early June, CMS Administrator McClellan indicated that nearly 2.3 million enrollees were members of Medicare Advantage plans with exclusive card programs who were auto-enrolled. Information on the number of beneficiaries who have enrolled outside of a Medicare Advantage plan or a state pharmacy assistance program is not available, but published reports from some card sponsors suggest direct enrollment has been slow.

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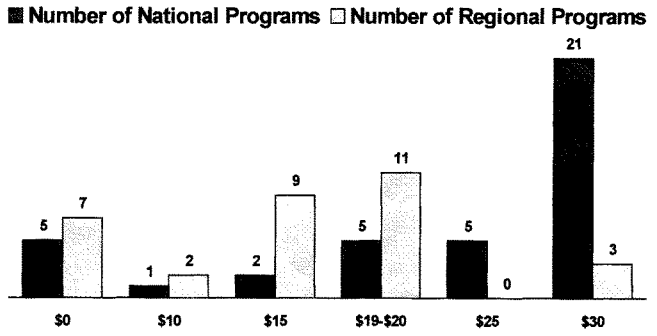
[13] *Federal Register*, Dec. 15, 2003, p. 69922

[14] One national card (ArgusRx) charges a lower enrollment fee for enrollees living in two states; two regional cards (Priority Plus and PrimeScript) charge lower enrollment fees for enrollees living in certain states. Centers for Medicare and Medicaid Services, *Approved General Cards*, www.cms.gov [for web posting_master_approved-generalsponsors-by product_06022004.xls]

[15] Discrepancies in enrollment fee amounts have occurred between the various documents posted on www.cms.gov, the individual card program websites, and the Medicare.gov PDAP, probably due to data errors. A spokesman for CMS says that card fees have not changed and that the PDAP has the correct amounts. Personal communication with CMS, July 15, 2004.

Figure 3

Annual Enrollment Fees For Medicare-Approved Drug Discount Cards



SOURCE: Centers for Medicare & Medicaid Services (CMS).
NOTES: Current as of July 11, 2004. Some regional card programs charge different fees in different states.

Covered Drugs and Formularies

The MMA requires that Medicare-approved discount card sponsors offer enrollees discounts on "covered drugs". The law applies the same definition of covered drugs for the discount card program as for the new Part D drug benefit that becomes effective in 2006, which is basically the same definition that is applied under Medicaid, with minor exceptions. Generally, the definition includes all FDA approved drug and biological products available only by prescription, and necessary supplies for the injection of insulin. Drugs currently covered under Medicare Part B continue to be reimbursed under Part B and are not considered Part D covered drugs. Table 2 presents a complete list of those categories of drugs that are excluded.

Table 2. Categories of Drugs Excluded from Coverage under Medicare-Approved Drug Discount Card Programs
Barbituates
Benzodiazepenes
Cosmetic drugs
Drugs covered under Part A or Part B
Drugs that relieve coughs or colds
Fertility drugs
Over-the-counter drugs or drugs that do not require a prescription*
Vitamins (except prenatal)
Weight-related drugs
*Card sponsors are permitted to offer discounts on these types of drugs. However, the $600 TA credit cannot be used for over-the-counter drugs, except insulin.

The regulations allow endorsed discount card sponsors to establish formularies, i.e., lists of drugs for which discounts are available within the overall universe of drugs that fall within the definition of covered drugs. The preamble to the regulations notes that "while clinical appropriateness must be foremost in the development of a formulary, a properly designed formulary can also promote lower costs for beneficiaries as pharmaceutical manufacturers compete using, among other things, rebates, volume discounts, and generic drugs to supply the drugs that meet the formulary requirements at the lowest price."[16] Card sponsors are required to offer a discounted price on at least one drug in each of 209 categories developed by CMS and published in the regulations. In addition, sponsors must provide at least one generic drug in 95% of the categories for which a generic is available (55% of the 209 categories). The categories specified in the regulations were developed by CMS through a contractor by reviewing data on the drugs most commonly used by Medicare beneficiaries.

While a sponsor is required to meet the general formulary requirement of one drug in each of the 209 categories, it may decide to provide discounts on all FDA approved drugs or a subset of drugs. A card sponsor can change its discounted drug list or the discounted prices at any time. Such changes have to be published on the sponsor's website and updated weekly on the Medicare.gov website.

This formulary flexibility has troubled beneficiary advocacy groups who fear that beneficiaries drawn to a particular card program on the basis of an initial drug list may subsequently find that the list of discounted drugs has changed. Such drug list modifications may be more problematic in 2005 when the selection of a card generally "locks-in" the beneficiary for a full twelve months (exceptions are possible for special circumstances). The CMS has responded to this concern asserting that drug plan sponsors have a strong incentive to maintain a stable drug list (formulary) for the following reasons: (1) sponsors need a lot of enrollees (i.e., "covered lives") to negotiate good deals for enrollees and to cover their card program operating costs; (2) satisfied enrollees are more likely to remain in 2005; (3) satisfied enrollees will be more likely to stay with a sponsor if it offers a Part D drug plan in 2006; and (4) sponsors need experience of Medicare beneficiaries' utilization under the drug card program to help them anticipate costs and risks under the Part D benefit.[17]

There is no practical way to analyze the extensiveness of the formularies of each of the discount card sponsors. The PDAP only responds to drug-specific queries, thus making it extremely laborious to ascertain the universe of drugs included in a card's formulary. Card sponsors vary as to how they describe on their own websites or in their brochures the products available at a discount through their programs. Some programs claim to offer a discount on all products that meet the Medicare definition of covered drugs. Others use adjectives such as "most" or "many" to describe drug availability through their program. Many programs provide beneficiaries with partial lists that contain those drugs that are most frequently prescribed and indicate that a complete list of discounted drugs and prices can be obtained from their toll-free telephone service and mailed upon request. Most of the programs offering a more limited list of discounted drugs suggest that the enrollee show their physicians the list of discounted drugs to improve the likelihood that the physician will prescribe a drug on that list.

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[16] Federal Register, December 15, 2003, page 69852.

[17] Centers for Medicare and Medicaid Services, FAQs: What are the rules for drug card sponsors to drop drugs from their formularies? http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_cat_lvl1=77&p_cat_lvl2=78

Beneficiaries who use very high cost drugs may need to be especially vigilant in checking the availability of their drugs at a discount under the specific card options. Drugs that are used to treat various forms of cancer, rheumatoid arthritis, HIV/AIDS, and multiple sclerosis, for example, can cost thousands of dollars a month. Some of these products are biologics, however, and require special handling.

Beneficiaries who use very high cost drugs may need to be especially vigilant in checking the availability of their drugs at a discount under the specific card options.

They may not be obtainable at local pharmacies, or through mail order, or the card program may not include them at all. Using the Medicare.gov PDAP, we tested how the card programs would treat eight of these high priced drugs for a beneficiary living in Baltimore (21211). As shown in Table 3, this beneficiary would have a maximum of 34 general national and regional card programs from which to choose for lower-cost, frequently prescribed medications. For these high-priced drugs, however, prices were available for three of the drugs for all 34 cards, but they were only available for 24 of the cards for the Multiple Sclerosis drug, Avonex. More but not all card programs offered prices on Thalomid, Humira, Avonex, and Tracleer. Similar results were found for a rural California county (93635). Our results suggest that beneficiaries needing these types of drugs may have to check with the specific card programs about both availability of the drugs and their prices.

Table 3. Availability of Discounts from General National and Regional Medicare-Approved Drug Discount Cards for Selected High-Cost Drugs

Baltimore, Maryland 21211 – Retail pharmacies within a 2.25 mile radius

Use	Drug Name	Dosage/30-day	# cards (out of 34) with drug	# cards for which prices are not available for the drug
AIDS drug	Epivir	150 mg	34	--
Anti-cancer-myeloma	Thalomid	100 mg	25	9
Breast Cancer	Tamoxifen	10 mg	34	--
Rheumatoid Arthritis	Humira	2@40mg/.8mL	31	3
CMV Retinitis/AIDS	Valcyte	450 mg	34	--
Multiple Sclerosis	Avonex	4@30/.5ML kit	24	9
Pulmonary Hypertension	Tracleer	62.5 mg	32	2

Source: www.Medicare.gov. PDAP. Data are for the week of July 5, 2004.

The implications of the extensiveness of a formulary for a discount card program are less significant than they will be for the Part D drug benefit. The discount cards are not insurance; the enrollee remains responsible for paying the entire cost of prescriptions (although TA enrollees do receive the $600 per year subsidies). Enrollees pay the lower of the pharmacy price or their card's discounted price. They are free to not use their card if they can find lower prices for certain drugs at other retail outlets or with discount card programs that are not endorsed by Medicare. Moreover, the law provides that enrollees receiving TA may use those funds for any prescription, regardless of whether a discounted price is available through their card program. Under the Part D benefit program, plans may structure formularies so that there is no coverage for drugs not on the formulary (unless they are found necessary upon appeal), or to require higher out-of-pocket cost-sharing for drugs that do not have "preferred" status. Thus, the choice of drug plan may have much greater financial consequences for the enrollee, and beneficiaries will need to be more thorough in analyzing the formularies associated with their Part D plan choices.

Drug Pricing

Negotiated prices. Medicare-endorsed discount card programs are required to obtain "negotiated prices" on the prescription drugs they cover. The regulations define negotiated price as "the discounted price for a covered discount card drug offered by an endorsed sponsor, including any dispensing fee, which takes into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations." [18] Sponsors are required to pass through to enrollees some of these price concessions, but no minimum quantitative standard is established. [19] In explaining this decision not to establish any minimum standard for passing through discounts, the preamble to the regulation states that "doing so would have the unintended effect of undercutting market competition as endorsed sponsors might cluster their drug prices around that threshold."[20]

Reporting of price concessions. Drug card sponsors are required to disclose to the Secretary of HHS the percentage of pharmaceutical manufacturer price concessions or rebates passed through to enrollees. The law requires that this information be protected as proprietary pricing information in the same way drug price reporting is protected under the Medicaid statute. CMS will not release any non-aggregated data in a format that discloses the identity of any particular drug rebate, manufacturer, or wholesaler.

Price changes. Card sponsors are allowed to change the price of drugs at any time. However, because enrollees are generally "locked-in" to their enrollment in a particular program for a calendar year, any price increases cannot exceed an amount proportionate to the change in the drug's average wholesale price (AWP) and/or an amount proportionate to changes in the sponsor's cost structure (e.g., rebates, discounts, etc.) for the product. CMS has indicated that it is hiring a contractor to monitor price changes in order to enforce this requirement.[21] As of July 1, 2004, the identity of the contractor had not been announced.

Medicaid "best price" exception. The MMA excepts prices negotiated by Medicare discount card programs with pharmaceutical manufacturers from the Medicaid law requirement that pharmaceutical manufacturers provide Medicaid programs with the lowest price (i.e., "best price") available from a manufacturer to any wholesaler, retail pharmacy provider or managed care organization. The exception is expected to allow card program sponsors to negotiate prices which in some cases will be less than paid under Medicaid.

Enrollees pay the lower of the pharmacy or their card's discounted price. They are free to not use their card if they can find lower prices for drugs at other retail outlets or with discount card programs that are not endorsed by Medicare.

Prices paid by beneficiaries. The drug prices quoted by card programs reflect the total cost to the consumer, including both the price for the pharmaceutical ingredients and the pharmacy dispensing fees. Card programs are required to ensure that the pharmacies participating in their program charge an enrollee no more than the lesser of the card program price, or the pharmacy's usual and customary price. Therefore, a card program enrollee is never to be penalized and pay a

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[18] *Federal Register*, December 15, 2003, p. 69916
[19] Only one card, Public Sector Partners Prescription Discount Card, claims to be passing on "100% of its discounts" to enrollees. www.publicsectorpartners.com/programs/summary.cmf, June 14, 2004
[20] *Federal Register*, December 15, 2003, p. 69861
[21] McClellan, Mark, Testimony before the U.S. Senate. Committee on Finance, June 8, 2004.

higher amount because of participation in an approved card program. Network pharmacies must inform enrollees of any differential between the price of their prescribed drug and the lowest priced generic equivalent available at the pharmacy. This information is to be provided at the time of purchase, or in the case of mail order, at the time the drug is delivered (presumably through a package insert). It is unclear, and the regulations do not clarify, if the generic price information is to be provided before the prescription is actually filled, so that the enrollee has the option to obtain the lower priced generic, or whether the requirement can be fulfilled by providing the information with the filled prescription, so that any change to the generic version could not occur until the prescription is refilled.

Deeper discounts. Card sponsors are allowed to vary prices and formularies among categories of enrollees, such as by income or disease status. The preamble to the regulations states that such flexibility will promote access to lower prescription drug prices for populations for whom prescription drug expenses are a significant burden.[22] While most of the card programs indicate that prices may vary by enrollee characteristic, the only characteristics by which prices appear to vary is income and that is true for some but not all cards. One card program, Public Sector Partners Drug Discount Card, says that it "passes 100% of discounts to PSP card members."

While most of the card programs indicate that prices may vary by enrollee characteristic, the only characteristics by which prices appear to vary is income and that is true for some but not all cards.

Some discount card programs indicate on their websites that they have negotiated "additional" or deeper discounts with certain manufacturers on certain products. Treatment of these programs on the Medicare.gov PDAP has evolved, and as of mid-July, PDAP now links each card program to a page showing "Special Features," including whether the program has such manufacturer agreements. More information is provided below (see: "Drug Manufacturer Discount Card and Patient Assistance Programs").

Pharmacy Access

Card sponsors must demonstrate that enrollees will have convenient access to covered drugs at a discounted price by securing the participation of a sufficient number of pharmacies that dispense drugs (other than solely by mail order) directly to card enrollees. By regulation, "convenient access" is defined to mean that, in urban areas, at least 90% of card enrollees live within 2 miles of a contracted network pharmacy, in suburban areas, at least 90% of enrollees, on average, live within 5 miles of a contracted network pharmacy, and in rural areas, at least 70% of enrollees live within 15 miles of a network pharmacy.[23] The endorsed sponsor's retail pharmacy network may be supplemented by a mail order.

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[22] *Federal Register,* December 15, 2003, p. 69862

[23] *Federal Register,* December 15, 2003, p. 69918. These access standards are defined by statute and are based on the pharmacy access standards under the Department of Defense TRICARE program. Because of CMS concerns that these standards may be difficult to meet in some very rural areas, CMS requires only "that sponsors meet these standards at the program level, that is, across all of the states that comprise the sponsor's service area. Therefore, sponsors that wish to include rural states may need to also include more densely populated stated in their program's service areas in order to meet the statutorily defined access requirements." CMS also observes that drug card sponsors may offer mail order which "may provide a particular convenience for beneficiaries in rural areas." CMS, Drug Card Sponsor Questions & Answers, Last updated 5/6/2004, p. 25. www.cms.gov

There are about 57,500 retail pharmacies in the United States.[24] Of the 19 general national cards providing information on the size of their pharmacy network, 3 indicate that they have between 30,000 and 39,999 pharmacies, 12 have between 40,000 and 49,999, and 4 have 50,000 or more.[25] Many card sponsors provide a tool on their websites enabling the user to identify all or a sample of participating pharmacies in a zip code or state. (Some permit the user to identify pharmacies that offer 24-hour service.) Other card sponsors do not include specific pharmacy information on their website, but indicate that they will make their pharmacy list available upon request.

Card programs generally caution that pharmacy networks may change at any time.

Card programs generally caution that pharmacy networks may change at any time. Regional card programs appear to have somewhat smaller pharmacy networks, an observation that has not, however, been examined systematically. Complaints have emerged that some pharmacies listed as participating in specific card programs may not, in fact, be doing so. This may be a problem for some beneficiaries who base their choice of card programs on that program's list of pharmacies.[26]

To test whether pharmacy networks vary for urban and rural areas, we looked at the number of pharmacies offered by seven selected card programs for four hypothetical beneficiaries in Baltimore and rural Kansas (Ellsworth). It is not surprising that beneficiaries living in Baltimore have a larger number of pharmacies to select from and that are closer to home as measured by radius from the beneficiary's home zip code.[27] Whereas the number of pharmacies offering the card for Baltimore ranged from 11 to 22 for the different card programs (with the median being 22), the number for Ellsworth ranged from 7 to 15 (with the median being 14).[28] For some of the selected card programs, the number of network pharmacies changed from the first to the sixth week but the change was typically no greater than the addition or subtraction of one pharmacy. Whether this is because of actual changes or data corrections is not known.[29] This tentative finding does suggest the importance of tracking this question over a longer time period than six weeks.

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[24] Health Policy Alternatives, Inc. *Prescription Drug Discount cards: Current Programs and Issues.* Kaiser Family Foundation, February 2002, p. 11.

[25] Information was sought from the card sponsor's website. In a few instances where the website was not yet operational, information was obtained by calling the sponsor's toll-fee telephone number.

[26] This problem "seems to stem in large part from the way in which drug card sponsors developed their list of participating pharmacies. Many drug card sponsors used 'passive acceptance agreements' to identify participating pharmacies. Under these agreements, unless a pharmacy specifically told the sponsor that they would not be participating – and have no intention of participating – with drug card sponsors, [they] are listed as participants on the Medicare web site." Letter to Secretary Thompson from Representatives Henry Waxman and Louise Slaughter, July 6, 2004.

[27] The Medicare.gov PDAP requires the user to indicate, for the zip code selected, the distance ("radius") for which it should display pharmacies for the available card options. Because of the large number of pharmacies in urban areas, we used 2.25 miles for Baltimore (21211). For Ellsworth (67439), we began with 11.75 miles but needed to increase the radius to 37.5 miles to capture the seven selected card programs.

[28] Note that the pharmacy totals for the seven selected card programs for each of our beneficiaries varied somewhat, presumably because some pharmacies within a network might not supply a specific drug.

[29] We did not check to see whether the change was simply in the totals or whether the specific pharmacies also listed in the network also changed.

Of the 34 general nationwide card programs actively marketing in June 2004, at least 26 offer mail order. Sometimes the mail order option is provided through the same organization such as a PBM; sometimes it is a separate entity. For example, some contract with Medco, Express Scripts, or Caremark-AdvancePCS, three of the nation's largest PBMs that operate mail order pharmacies. A few, however, contract with Drugstore.com. A mail order option may be especially useful for Medicare beneficiaries who are home-bound or live in areas where pharmacies are few and far between, especially for medications used on an ongoing basis. Depending on the card program, mail order also may provide for greater savings and convenience, a reason why many people use it even when neighborhood pharmacies are nearby.

A mail order option may be especially useful for Medicare beneficiaries who are home-bound or live in areas where pharmacies are few and far between, especially for medications used on an ongoing basis.

Some mail order options can be used for 30-day supplies; most tend to offer the best prices for 90-day supplies. Information on whether a card sponsor offers a mail order option can usually be found on the card sponsor's website. In addition, the PDAP allows the user to specify whether the display for their zip code and set of drugs includes card sponsors that offer a mail order option. The Medicare-approved discount card programs build in any shipping costs for normal deliveries to the drug price; enrollees are not charged a separate shipping charge for using the mail order option unless they request expedited delivery.

Some card program sponsors that do not offer mail order (and at least a few that do) indicate that discounts on 60- or 90-day supplies are available at their participating retail pharmacies. For these sponsors, it is likely that this option is included to help retail pharmacies -- who may also be partners in the card program -- retain customers not only for the prescription medications but for the other items sold by the pharmacy.

Medicare Advantage Plans and the Medicare Discount Card Program

Organizations with Medicare contracts under Part C (Medicare Advantage (MA) risk plans as well as plans with cost contracts and PACE programs) are eligible to offer general Medicare-endorsed discount card programs (including administration of TA for eligible enrollees). In general, Part C organizations must comply with the rules established for all discount card program sponsors. However, some special provisions apply for those MA plans that wish to offer programs exclusively to their Medicare enrollees (called exclusive drug cards). Other types of Part C plan organizations (e.g., private fee-for-service plans) that meet the discount card sponsor qualifications must make their endorsed programs available to all eligible individuals in their service area(s).

If an MA plan offers an exclusive discount card program, plan enrollees are only allowed to enroll in the plan's discount card program. Since the program is voluntary, MA organizations must allow their Medicare enrollees to decline enrollment, but if they do decline, they may not enroll in any general card program. If an MA organization does not offer an exclusive card program, their enrollees may participate in any general endorsed card program available to them in their area of residence. The same rules apply regarding the lock-in to one program and the ability to change card programs only during the annual coordinated election period or special election periods.

If an MA plan offers an exclusive discount card program, plan enrollees are only allowed to enroll in the plan's discount card program.

The Medicare discount card requirements that are waived for all exclusive card programs include:

- having at least a statewide service area;
- offering enrollment to all Medicare beneficiaries;
- pharmacy access standards if the plan operates a network that is not limited to mail order and meets provider access standards applicable to managed care plans;
- having a minimum one million covered lives; and
- the requirement that TA only be applied towards covered drugs (Part C plans are allowed to apply TA funds to cost-sharing requirements for their pharmacy benefits).

As of June 16, 2004, 84 organizations had been approved to offer exclusive discount card programs to enrollees in 457 Medicare managed care plans. In only 38 of the MA plans is payment of an enrollment fee for the discount card required: 29 plans charge $30 and in 9 the fee is $29. The fact that most of the plans do not require an enrollment fee is likely due to the fact that MA organizations are allowed to provide coverage of the discount card enrollment fee as a benefit in fulfilling any extra benefit requirements under their MA contract and must report such as part of their adjusted community rate filings.

The original CMS application solicitation for Part C organizations interested in offering discount cards indicated that the exclusive card program sponsors could request a waiver of the requirement that formularies and drug pricing information be made available on the PDAP website. In fact, however, the exclusive card programs were completely excluded from PDAP, and no comparative pricing information for these exclusive card programs is available on the PDAP website.

MA plan sponsors choosing not to offer a Medicare-endorsed discount card may have done so for a number of reasons. Some organizations already provided their enrollees with pharmacy discount cards and did not perceive sufficient advantage to having their cards receive Medicare endorsement. Other organizations may have been deterred by the short time frame and complicated application process. Others chose to partner with a general card sponsor and/or offer to pay all or part of the enrollment fee in a general card program as a more efficient way to provide members with access to discounted prices.

Coordination with State Pharmacy Assistance Programs

State Pharmacy Assistance Programs (SPAPs) are state-sponsored programs that provide senior citizens and, in some states, individuals with disabilities, increased access to affordable outpatient prescription drugs. Generally funded exclusively by state dollars, these programs have been increasing both in number and expenditures. As of July 2004, 31 states had programs in operation, and eight additional states had enacted laws to establish them but had not yet implemented them.[30]

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[30] National Health Policy Forum: *The Basics. State Pharmacy Assistance Programs,* April 26, 2004, www.nhpf.org; National Conference of State Legislatures, *State Pharmaceutical Assistance Programs*, www.ncsl.org

Most of the states have direct-benefit programs where they subsidize a significant share of the prescription drug costs of their enrollees. Six states offer discount cards but no direct subsidy program. Eligibility levels vary but most SPAPs target low-income individuals who are not eligible for Medicaid, are 65 or older, or are disabled. Income thresholds range from 100% of the federal poverty level (Wyoming) to as high as 500% (Massachusetts). Some SPAPs offer benefits regardless of an individual's income, but with higher cost-sharing as income rises. Most SPAPs cover most drugs in a therapeutic class through the use of open formularies; a small number, however, use closed formularies. A majority of the states offering direct benefit programs also offer discount programs.[31]

The SPAPs, with their widely varying eligibility criteria and benefits, are taking their own paths in the precise manner in which they coordinate with the Medicare discount card program.

Medicare beneficiaries who are enrolled in an SPAP (other than those funded under Medicaid waivers) may also enroll in a discount card program.[32] If a beneficiary establishes eligibility for TA, he or she receives the $600 credit and then the SPAP typically wraps its coverage around the TA credit. This means that the beneficiary will first buy her drugs using the TA credit. The SPAP may fill in the required cost-sharing and help with the cost of drugs once the credit is exhausted. The SPAPs with direct benefits stand to save significant amounts of money as a result of the TA program. Whether these savings are used to expand eligibility or benefits remains to be seen. At this juncture, it appears that the SPAPs, with their widely varying eligibility criteria and benefits, are taking their own paths in the precise manner in which they coordinate with the Medicare discount card program.

The value of the Medicare discount card program to lower-income individuals who are not eligible for TA but who are enrolled in a SPAP is also likely to vary by state. In some states, there may be few or no enrollees with incomes above that needed to qualify for TA; in others, with higher income eligibility thresholds, there are significant numbers of enrollees who will not be eligible for TA. Often, non-TA eligible enrollees can get drugs at lower out-of-pocket costs through their SPAP than they could through the Medicare discount card program. For this reason, many SPAPs are advising enrollees not to obtain a Medicare discount card.[33]

SPAPs and Auto-Enrollment. One of the major issues initially facing states has been whether they would be permitted to enroll automatically Medicare beneficiaries who participate in their SPAPs in specific discount card programs. The major rationale for doing this is to better coordinate the SPAP with the TA credit and the Medicare discount cards and accrue savings for these states. CMS has decided to allow states to do this, known as "auto-enrollment," or "auto application" but only if the state is the individual's authorized representative. Auto-enrollment is permitted for all beneficiaries enrolled in an SPAP, not just those qualifying for TA.

Beneficiaries who are auto enrolled into a card program must be given the opportunity to decline the card or to switch to a different card program. Before the auto-enrollment occurs, states electing this procedure are required to send a notice to SPAP enrollees explaining what is happening, the consequences of auto enrollment, whether enrollment in the card is

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[31] National Health Policy Forum, April 26, 2004.

[32] Enrollees in state AIDS Drug Assistance Programs (ADAP) are also eligible to participate in the discount card program and to apply for transitional assistance (if they meet the income eligibility criteria). CMS. Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 47.

[33] Testimony of Kimberly Fox, Center for State Health Policy at Rutgers University, to the State Pharmaceutical Assistance Transition Commission, July 7, 2004.

required for participation in the SPAP; how the individual can opt out, and whether there is a card program enrollment fee. (The fee would apply only to non-TA enrollees, but most states are not auto-enrolling them.)[34]

If the state is not the individual's authorized representative, the state is permitted to send a letter to its SPAP enrollees seeking permission from the beneficiary to apply for TA on the person's behalf (or take other appropriate steps as provided under state law). Once the person's permission is obtained, then the state can do auto-enrollment. States are also permitted to facilitate enrollment in a specific drug card program and to apply for TA by completing the form on behalf of the individual, and providing the form to the individual to return it (signed) to the card sponsor.[35]

As of June 10, 2004, SPAPs in seven states (CT, ME, MA, MI, NJ, NY, and PA) had arranged with CMS to auto-enroll their recipients in a drug card and the TA program. In addition, Ohio and Rhode Island had provided enrollees with applications that were already filled out and required only the beneficiary's signature. SPAPs in CT, ME, MA, NJ and Ohio cover both the aged and the under-65 disabled; NY, PA, and RI only cover those 65 and older. As of the same date, the other SPAPs did not have plans to do auto-enrollment. CMS has given SPAPs the permission to exclusively contract with a Medicare-approved discount card program. Pennsylvania's PACE, for example, is exclusively contracting with First Health, which has served as PACE's TPA.[36] One state, Connecticut, chose to implement auto-enrollment with several cards instead of using an exclusive arrangement.

As of June 10, 2004, SPAPs in seven states (CT, ME, MA, MI, NJ, NY, and PA) had arranged with CMS to auto-enroll their recipients in a drug card and the TA program.

Drug Manufacturer Discount Card and Patient Assistance Programs

Many pharmaceutical manufacturers sponsor programs that provide free or discounted drugs to targeted populations. Information on these patient assistance programs is linked to the Medicare.gov website.[37] Many of the larger drug companies also sponsor and/or have partnered with other companies to offer drug discount cards. GlaxoSmithKline, for example, sponsors the "Orange Card;" Eli Lilly sponsors the "LillyAnswers" card; Novartis sponsors the Novartis CareCard; and Pfizer sponsors the "Share Card." The "Together Rx" card program was founded by a consortium of 8 drug manufacturers, including Eli Lilly, GlaxoSmithKline, Novartis and Pfizer. Drug companies established these discount card programs for their drugs in 2001-2002 in the heat of debate over the Medicare drug benefit and targeted them largely to low-income Medicare beneficiaries who lack insurance coverage for prescription drugs.

How will these programs work with the Medicare discount cards? The Pfizer Share Card program has announced that it will end on August 31, 2004, but through Pfizer's participation

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[34] CMS, Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 51.
[35] CMS, Drug Card Sponsor Questions & Answers, updated 5/6/2004, p. 51.
[36] Presentation of Thomas Snedden, Pennsylvania PACE, National Health Policy Forum meeting, May 14, 2004.
[37] In May 2004, Wisconsin introduced a new website (www. Rx4Wisconsin.org) to help connect qualified low-income residents connect with discount drugs, through drug manufacturer patient assistance programs. Such information can also be obtained from the ABC Rx Coalition's website: http://www.accesstobenefits.org/Find%20Rx%20Savings/.

in the Medicare-approved "U Share Prescription Drug Discount Card," Pfizer will continue to make available most of its drugs to enrollees at $15 per 30-day supply.[38] Eli Lilly announced in January 2004 that it would offer the "LillyAnswers" discount to low-income enrollees below 200% of the federal poverty level in all Medicare-approved discount card programs. Lilly drugs would be available for only a $12 fee for a 30-day supply. Lilly also indicated that it would provide discounts on Lilly medications for approved card program enrollees with incomes greater than 200% of the federal poverty level.[39] Lilly, like Pfizer, is also a cosponsor of the U Share Prescription Drug Discount Card Program. Together Rx says on its website that it plans to continue to assist cardholders until 2006, when the drug benefit becomes available. "Together Rx is structured to allow each member company to make individual decisions as to whether to continue its participation, the savings that it offers, and its product offerings, which can be periodically modified."[40] It is not known whether the other companies with discount card programs will respond like Pfizer's "Share Card" and be transitioned to a Medicare-approved card or, like Together Rx, continue to operate outside the Medicare-approved card program through the end of 2005.

Transitional Assistance Enrollees. As of mid June 2004, CMS indicated that seven pharmaceutical manufacturers had agreements with Medicare-approved discount card sponsors to provide additional discounts to TA individuals once they exhaust their $600 credit. This information has been gradually updated and is now described on the PDAP as the "Expanded Medicare Assistance Programs."[41] (See also Figure 4 on the following page.) For each of these manufacturer programs, there is a different list of sponsors with which they have agreements, and the programs vary on whether the enrollee is required to pay anything for the drugs that are included in the agreement. For example, Novartis and AstraZeneca are providing prescription drugs free to TA-eligible Medicare enrollees after they exhaust the $600 credit, except that enrollees are "responsible for any pharmacy fees, such as a dispensing fee, negotiated by your card sponsor." An earlier Novartis announcement estimated these to be $5 to $10 for most medications.[42] Under the Eli Lilly agreement, once the $600 is spent, the TA-eligible enrollee will be charged $12 for a 30 day supply of a specific set of Lilly drugs, plus any pharmacy fees, such as a dispensing fee, as negotiated by the card sponsor." With Merck's program, once a TA enrollee has exhausted the $600 credit, the person will be able to purchase Merck medications for the rest of the year, paying only a pharmacy dispensing fee. As noted above, Pfizer has indicated that it will allow beneficiaries to purchase medications for a flat monthly fee of $15 (30-day supply) for those participating in the Medicare-approved "U Share Card" program.

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[38] http://www.pfizersharecard.com/homenew2.asp?cardImageOver=8&cod=2, July 6, 2004

[39] If this is the case, then some card programs have not yet indicated on their websites the availability of these discounts on Lilly drugs. For the announcement, see: http://www.lillyanswers.com/en/news/pr_1.html, July 6, 2004.

[40] http://www.togetherrx.com/faq.html, July 6, 2004

[41] The PDAP page that lists the approved discount card programs for a beneficiary in a zip code includes information for some card programs on how their programs interact with manufacturer patient assistance programs. This list has tended to lag behind the actual number of manufacturer agreements. A "master list" now appears on the cms.gov website. Although the PDAP shows the actual price a TA enrollee would pay for each drug for each card (for each pharmacy) before he or she exhausts the $600 credit, it does not show the extra savings from the manufacturer discounts.

[42] *Health Care Daily*, Novartis to Offer Free Medications to Low-Income Seniors With Drug Cards, April 15, 2004; *Health Care Daily*, Merck Offers Free Medications For Some Low-Income Senior Citizens, February 17, 2004.

Some manufacturers have also entered into arrangements with certain card sponsors to offer additional discounts to enrollees who are at income levels that disqualify them for transitional assistance. In some instances, it is not clear from the card sponsor's website when such additional discounts are available and to whom. For others, it is clearly indicated that the additional discounts are available for enrollees who fall below certain income thresholds for some drugs manufactured by a named company. For example, Wellpoint's Precision Discount Card (Option A) provides additional discounts for Lilly drugs for enrollees who have $18,000 to $24,000 in household income. Income information is requested on the enrollment form as an optional question. Community Care Rx and Criterion Advantage, sponsored by Computer Sciences Corporation, indicate that they will provide additional discounts for lower-income enrollees for selected drugs of certain manufacturers. Again, optional income information is solicited on the cards' enrollment forms.

Seven pharmaceutical manufacturers have agreements with Medicare-approved discount card sponsors to provide additional discounts to TA individuals once they exhaust their $600 credit.

Figure 4

Availability Of Assistance For Low-Income Beneficiaries After Exhaustion Of $600 Credit

Agreements Between Drug Manufacturers and Medicare-Approved Drug Discount Card Programs to Provide Additional Discounts

Drug Manufacturer	Number of Agreements
Abbott	4
Astra Zeneca	6
Eli Lilly and Company	27
Johnson & Johnson	12
Merck	27
Novartis	20
Pfizer	1

SOURCE: www.cms.hhs.gov/medicarereform/drugcard/mfragreements.asp, July 6, 2004.
NOTES: On July 7, 2004, Pfizer announced that it will give access to many of its drugs for a flat fee of $15 per prescription for low-income beneficiaries who are enrolled in any Medicare-approved drug discount card. Press release, www.pfizer.com.

BENEFICIARY OUTREACH, EDUCATION AND SAFEGUARDS

Critical to a successful implementation of the Medicare drug discount card program is getting clear and consistent information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Educating beneficiaries has proved to be a significant undertaking because of the large number of card options, and the challenge of communicating with over 40 million seniors and people with disabilities. The Medicare.gov PDAP alone includes information on nearly 60,000 drug products and 75,000 pharmacies, according to CMS Administrator Mark McClellan.[43] Choosing the card that offers the best value for an individual requires consideration of a large amount of comparative data and the availability of tools to support informed decision making.

Educating beneficiaries has proved to be a significant undertaking because of the large number of card options . . . . The Medicare.gov PDAP alone includes information on nearly 60,000 drug products and 75,000 pharmacies.

The challenge of mounting an outreach and education effort on the scale required to reach all beneficiaries cannot be over stated. A survey sponsored by the Kaiser Family Foundation in April 2004 found that nearly one-half of Medicare beneficiaries held an unfavorable impression of the MMA. Fifty-four percent of survey respondents reported that they didn't know enough about the MMA to say whether it included a Medicare drug discount card program. And, three quarters of surveyed beneficiaries said they did not know whether cash subsidies were available for some with a Medicare discount card. These results illustrate both the need for an aggressive educational effort and the magnitude of the challenge. [44]

CMS Education and Outreach

The MMA directs the Secretary of HHS to undertake a number of specific information and outreach activities to ensure broad dissemination of program features, eligibility rules, and comparative information. In response, HHS through CMS has initiated a broad range of information and enrollment-related activities to inform Medicare beneficiaries about their card options and assist them in enrolling in the card program of their choice. In addition, the agency is working with a large number of private and public agencies to provide beneficiaries with the opportunity to talk directly with trained volunteers about the details of the card program.

The 1-800 toll-free telephone line with trained customer service representatives and the CMS.gov and Medicare.gov websites displaying comparative information on the approved card options, enrollment fees, pharmacy networks, prices for the drugs covered under the program, and enrollment applications has been a major undertaking. As noted above, the PDAP found on medicare.gov was built on an existing site offering detailed information on state pharmacy assistance programs and patient assistance programs sponsored by some drug manufacturers.

Staffing for the 1-800-Medicare information line has been progressively increased over the last several months as the volume of calls has increased. Inquiries can be handled in English or Spanish, but there is only limited availability of other language support and no capability to

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[43] Mark McClellan,Testimony before Senate Finance Committee, June 8, 2004.

[44] Kaiser Family Foundation, 2004, *Selected Findings on the New Medicare Prescription Drug Law, Health Poll Report Survey* (conducted April 1-5, 2004), www.kff.org.

communicate in Asian languages. Nearly 2,800 customer service representatives at six call centers were handling as many as 150,000 inquiries per day in early June.[45] Waiting times for customer service representatives are being reduced, and now it takes less than 2 minutes on average to speak with a customer service representative, down from 14 minutes on average a month ago.[46]

The comparative information on card programs presented on the PDAP is in a format intended to assist beneficiaries in choosing a card. CMS has continually refined the tool and made it simpler to use. Still, in order to obtain a list of specific drug prices for cards accepted by pharmacies near a beneficiary's residence, it is necessary to enter the appropriate zip code, and a list of drugs taken with the strength and frequency. Following the complete PDAP inquiry process also requires the individual to enter income and insurance coverage data, which are used to determine whether the beneficiary is eligible for general enrollment and for $600 in transitional assistance. The PDAP also can provide prices for generic alternatives to brand name drugs (although it does not provide brand names if the person enters the generic) or expand the range of card and pharmacy choices by asking for a report on cards in a wider geographic area.

Beneficiaries may also request this same information by calling the Medicare toll-free number and requesting a printed copy of comparative information be mailed to them. However, to use the phone for this purpose a beneficiary must be prepared to answer specific questions about the drugs they are taking, the strength and frequency of dosing, which pharmacy or pharmacies they wish to use, and whether they want information on mail order options and generic drugs. Some beneficiary counseling centers offer help in assembling the information necessary to make a complete and accurate inquiry.

Of those beneficiaries who use the Internet, just 2% had visited the main government website designed for beneficiaries (www.Medicare.gov).

While the PDAP and the toll-free telephone service can help to identify a card program offering the best value for a beneficiary, the volume of information on available cards and participating pharmacies can be overwhelming. Printed reports on card options in many areas can run over 50 pages depending on the number of drugs and the size of the geographic area included in a beneficiary's request. Media reports suggest delays in reaching operators at 1-800-Medicare are also a source of significant frustration for many beneficiaries, although this problem appears to be subsiding.

An April 2004 survey sponsored by the Kaiser Family Foundation (KFF)[47] shows that use of the Internet by seniors is growing but overall remains low. About 70% of those age 65 or over report never using the Internet. Of those who do go online, just 2% had visited the main government website designed for beneficiaries (www.Medicare.gov). Internet use also varies significantly by income. For those with annual incomes below $20,000, only 15% have ever visited the Internet, while 65% of beneficiaries with incomes above $50,000 have gone online. These results suggest that direct decision support for beneficiaries through the Internet is still quite limited, although it may be available to individuals through family members.

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[45] Leslie Norwalk, Orlando Sentinel, June 1, 2004.
[46] Mark McClellan, Testimony before the Senate Special Committee on Aging, July 19, 2004; testimony before the Senate Finance Committee, June 8, 2004.
[47] Kaiser Family Foundation, *Selected Findings on the New Medicare Prescription Drug Law*, 2004.

HHS has also taken a number of other steps to acquaint beneficiaries with the approved drug card programs:

- Print, radio, and television advertisements have been prepared and placed in major media outlets—television time for just two ads totals $18 million.
- The Secretary sent a mailing to all Medicare beneficiaries in February 2004 with an enclosed "Fact Sheet" previewing the upcoming card program and the drug benefit scheduled for 2006.[48]
- In April 2004, HHS mailed to all beneficiaries a three-page introduction to Medicare-approved discount cards highlighting the beginning of the enrollment period on May 1 and the availability of $600 in TA for beneficiaries below the statutory income ceilings.
- In April 2004, CMS sponsored a conference to train state and voluntary agency staff on the policies and enrollment procedures for card programs.
- The Social Security Administration in April mailed a letter to low-income beneficiaries with information on how to access TA benefits.
- Finally, HHS prepared a guide to choosing a discount card and a briefer "tip sheet" to aid in the enrollment process – both of which are available upon request or at Medicare.gov and from organizations partnering with HHS to assist beneficiaries with their card decisions.

In addition to these outreach efforts, funding for the state health insurance assistance programs (SHIPs) was increased from $12.5 million in 2003 to $21.1 million this year. These organizations provide personal assistance to Medicare beneficiaries regarding all of their health coverage options. Recently, HHS announced an additional $4.6 million in grant funds for community-based organizations to target assistance to low-income beneficiaries. Members of the Access to Benefits Coalition (ABC)[49] are among the eligible recipients in 30 targeted urban communities across the country where approximately 70% of low-income beneficiaries reside. Another $2 million is being made available to Area Agencies on Aging to help enroll low-income beneficiaries in the transitional assistance benefits. Additional funds ($200,000) have been allocated to the Indian Health Service for similar activities.[50]

Congress authorized HHS to spend an additional $1 billion on activities related to launching the card program and the Part D prescription drug benefit. While a total figure on funds for education and outreach activities in support of the card program is not currently available, published expenditures for some of the activities noted above are nearly $50 million. Additional funds have been used to support contracts with Abt Associates for an evaluation of the card program and with another contractor to monitor and identify excessive price fluctuations in specific card programs.

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[48] Critics of this mailing requested a Government Accountability Office (GAO) opinion on whether it was purely informational or contained "publicity or propaganda" in violation of statutory prohibitions. GAO concluded that the mailing did not violate the law, but contained "notable omissions and other weaknesses." GAO. *Medicare Prescription Drug, Improvement and Modernization Act of 2004. Use of Appropriated Funds for Flyer and Print and Television Advertisements*, March 10, 2004(B-302504), p. 2-3.

[49] ABC includes over 68 organizations such as the AARP, the Salvation Army, the National Senior Citizens Law Center, and the American Hospital Association.

[50] DHHS Press Release, *HHS Announces New Collaborative Enrollment Initiative to Help Low-Income Medicare Beneficiaries Sign Up for Drug Discount Card*, May 27, 2004.

Card Sponsor Education and Marketing

Sponsors of drug cards are required to engage in specific education and enrollment activities. Among other requirements, sponsors must prepare information on covered drugs and prices, participating pharmacies, other products or services offered under the endorsement (e.g., discounts on over the counter medications), and enrollment fees for distribution in print and through the Internet. They must also maintain a toll-free telephone number to respond to inquiries and to advise enrollees with TA benefits of the current balance in their accounts. Current information on the balance in TA accounts must also be available at all network pharmacies at the time drugs are dispensed to an enrolled card member. Sponsors must also require their participating pharmacies to advise all card enrollees of the difference in price between a brand name drug and a generic product if available when prescriptions are dispensed.

Card sponsors may market their card options in a variety of ways including print and broadcast media, sales presentations upon request, flyers, and response cards. Sponsors are prohibited from any door-to-door solicitation or telemarketing approaches. Sponsors may also compensate others for their assistance in enrolling beneficiaries in a card program such as pharmacists subject to certain limits under the fraud and abuse laws (see below).

CMS regulations include a specific listing of the content for sponsor materials that must be available before and after enrollment of an eligible beneficiary. Among these items are:

- Details on covered drugs and prices and enrollment procedures;
- Availability of transitional assistance;
- Details on additional services such as drug utilization reviews and product alerts that are provided are no additional cost;
- Grievance procedures;
- The toll-free information telephone number;
- List of participating pharmacies;
- Enrollment fee and cost-sharing (if applicable);
- Notice that discount prices are subject to change; and
- Privacy protections.

Targeted outreach by HHS/CMS to physicians and pharmacists consists of making informational guides and other printed material available to providers upon request. Most card sponsors are also distributing materials for enrollment to participating pharmacies where beneficiaries are expected to seek information and advice.

Consumer Protections Against Fraud and Abuse

Law and Regulations. The MMA authorizes the Secretary to impose sanctions on sponsors of Medicare-endorsed discount cards for violations of program rules, including those pertaining to fraud and abuse.[51] These include: (1) civil money penalties (CMPs) of up to $10,000 for actions that the sponsor knows or should know violates a requirement of the discount card program; (2) other intermediate sanctions (such as suspension of outreach activities or enrollment of new beneficiaries); and (3) termination of participation in the discount card program.

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[51] Section 1860D-31(i)(3) of the Social Security Act (42 U.S.C. 1395w-141(i)(3))

Regulations implementing this authority identify the following forms of potential fraud and abuse that are subject to these sanctions:

- misrepresentation or falsification of information in outreach materials and comparable materials that a provided to beneficiaries and other persons;
- charging an enrollee in violation of the terms of the endorsement contract (e.g., charging for services the sponsor is required to provide without charge);
- charging an enrollment fee exceeding $30;
- charging a TA enrollee any enrollment fee;
- using TA funds in any manner inconsistent with their intended purpose;
- charging TA-qualified enrollees any coinsurance, and charging coinsurance in excess of 5% for enrollees below 100% of poverty or 10% for those between 100% and 135% of poverty;
- substantial failure to provide enrollees with negotiated prices consistent with information reported for the drug comparison website (medicare.gov);
- substantial failure to assure that any drug price increases do not exceed the increase in a sponsor's costs for the drugs; and
- substantial failure to comply with information and outreach guidelines (e.g., inclusion of information on products not directly related to discounted prescription drugs or to discounted over-the-counter drugs in marketing materials.[52]

Other laws enacted before the MMA also apply to fraud and abuse in the card program. The Office of the Inspector General (OIG) of the Department of Health and Human Services has made it clear that the anti-kickback laws[53] for Medicare and federally-funded State health care programs apply to the program. On April 8, 2004, it issued guidance indicating that payments by drug card sponsors to pharmacies for education and outreach activities could violate the anti-kickback laws if the payments result in steering Medicare beneficiaries to a particular discount card. The most obvious example of this would be basing such payments on the number of beneficiaries selecting the sponsor's card.[54]

Although the OIG has not identified other behavior in connection with the drug card program that could violate the anti-kickback laws, presumably it could also apply in other contexts, such as offering beneficiaries coupons or discounts on pharmacy services outside of the discount card endorsement.[55] Violations of the anti-kickback laws are a felony and are

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[52] *Federal Register*, December 15, 2003, p. 69863-64, 69869-70, 69877-78, 69918-19, 69922, 69925-26; Department of Health and Human Services, Office of the Inspector General, "Medicare and State Health Care Programs; Fraud and Abuse; OIG Civil Money Penalties Under the Medicare Prescription Drug Discount Card Program; Interim final rule and comment period", *Federal Register*, May 19, 2004, p. 28842-46.

[53] Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b).

[54] Office of the Inspector General, "Education and Outreach Arrangements Between Medicare-Endorsed Discount Drug Card Sponsors and Their Network Pharmacies Under the Anti-Kickback Statute," April 8, 2004(available at www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA040904.pdf). It should be noted that, although the anti-kickback laws generally prohibit the waiver of Medicare cost-sharing, the MMA made a specific exception that permits pharmacies to waive coinsurance for beneficiaries qualifying for transitional assistance if certain conditions are met.

[55] CMS has offered somewhat ambiguous guidance on this issue. In its December 2003 interim final rules on the discount card program, it indicated that the "Forthcoming information and guidelines"

punishable by fines of up to $25,000 and imprisonment for up to five years. Violations are also subject to CMPs of up to $50,000.

In addition, a 1988 law prohibits the use of words and symbols related to the Medicare program to give the false impression that an item is approved, endorsed, or authorized by Medicare. Violations are subject to CMPs of up to $5,000 or $25,000 violations consisting of a broadcast or telecast.[56]

Oversight and Monitoring. The program is in its early days and there have been no reports of enforcement actions taken against discount card sponsors beyond removing inaccurate pricing information from the program's price comparison website (www.Medicare.gov's PDAP). The only specific report of fraud to surface to date has involved persons misrepresenting themselves as Medicare officials or as representatives of Medicare-approved discount cards in an apparent effort to obtain personal information from beneficiaries that could be misused for other purposes. In April, before the program commenced operations, CMS reported that "some Medicare beneficiaries across the country (Alabama, Georgia, Idaho, Maryland, Nebraska, New York, Rhode Island, Virginia) have already received calls as well as in-person solicitations from individuals/companies posing as Medicare officials attempting to gain personal information from beneficiaries with the intent to scam the beneficiaries." [57]

There have been no reports of enforcement actions taken against discount card sponsors beyond removing inaccurate pricing information from the program's price comparison website.

In press releases and regulatory guidance, CMS and OIG have indicated that they are taking a number of steps to prevent and detect fraud and abuse. They include:

- Requiring card sponsors to submit all marketing and outreach materials for agency review prior to their use. The purpose of this review is to identify any false or misleading information, as well as the improper inclusion of prohibited information on products and services that are outside the scope of the card endorsement.[58]

- Monitoring the week-to-week changes in drug prices offered by card sponsors in order to detect "bait and switch" tactics (i.e., initially offering enrollees low prices and then raising them once the beneficiary has selected a card and is "locked in" for a period of time). According to CMS Administrator Mark McClellan, this monitoring will initially be done by CMS, but only until the agency has selected an outside contractor to conduct it.[59]

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would provide that card sponsors "may not ...provide cash or other monetary rebates (for example. coupons on pharmacy products and services) as an incentive for enrollment. (*Federal Register*, December 15, 2003, p. 69868). However, in its publication on "Drug Card Sponsor Frequently Asked Questions" (as of June 15, 2004), it indicates that sponsors can offer nominal ($15 or less) coupons or gifts to offset enrollment fees as long as they are "not a form of inducement to enroll...in the card program." (Question 25).

[56] Section 1140 of the Social Security Act (42 U.S.C. 1320b-10).

[57] CMS, "Fact Sheet: Medicare Beneficiaries Warned About Drug Card Scams" (April 22, 2004) (http://cms.hhs.gov/media/press/release.asp?Counter+1018). In addition, a June 1, 2004 report issued by the Center for American Progress suggested that the discount card company may be susceptible to fraud because 20 card sponsors have been involved in fraud charges in the past.

[58] *Federal Register*, December 15, 2003, p. 69868-69, 69872.

[59] CMS, " Medicare Implements New Steps to Prevent Drug Card Fraud," (April 22, 2004) (http://www.cms.hhs.gov/media/press/release.asp?Counter=1017) ; *Washington Healthbeat*, Stop

- "Mystery shopping" of the toll-free call centers card sponsors are required to maintain in order to identify false, misleading, or otherwise prohibited information practices. Although the precise meaning of the term "mystery shopping" is not defined, presumably this involves a caller who represents herself or himself as a Medicare beneficiary in order to determine the types of information a card sponsor actually conveys to beneficiaries.[60]

- Reviewing grievance logs that card sponsors are required to maintain as a condition of participating in the program.[61]

- Taking complaints and tips about fraud over the phone at 1-800-MEDICARE and the OIG's fraud hotline (1-800-447-8477).

- Issuing fraud alerts for use by publications read by seniors. For example, in response to anecdotal reports of persons falsely representing themselves as Medicare officials or agents of Medicare-approved drug discount cards, CMS issued a fact sheet on April 22, 2004 warning beneficiaries to "NEVER share personal information such as their bank account number, Social Security number or health insurance card number (or Medicare number) with any individual who calls or comes to the door claiming to sell ANY Medicare related product." [62]

Only additional experience will tell whether fraud and abuse will prove to be a significant problem under the discount card program.

PART II. DISCOUNT CARD PRICING ANALYSIS

To what extent do the Medicare-approved discount cards provide value to Medicare beneficiaries who otherwise buy their prescriptions at the full retail price? Do some cards provide better value than others?

Others have sought to answer this key question by comparing prescription drug prices obtainable using the Medicare-approved discount cards with prices that could be obtained through other means, including Canadian sources and the Federal Supply Schedule that is applicable to drugs obtained through the Department of Veterans Affairs.[63] Some analyses have factored in savings achievable for TA-eligible beneficiaries (including the $600 credit available in each of 2004 and 2005) as well as the extra discounts that may be available from some pharmaceutical manufacturers for some drugs through side agreements with the drug card sponsors.[64] Other analyses have focused on the prices obtainable by the Medicare

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Dissing Discount Cards, Grassley Tells Dems, June 8, 2004.

[60] *Federal Register, December 15, 2003,* p. 69877; CMS, " Medicare Implements New Steps to Prevent Drug Card Fraud," April 22, 2004.

[61] *Federal Register, December 15, 2003,* p. 69877.

[62] CMS, "Fact Sheet: Medicare Beneficiaries Warned About Drug Card Scams," April 22, 2004.

[63] U.S. House. Committee on Government Reform, Minority Staff, *New Medicare Drug Cards Offer Few Discounts*, Washington; D.C., April, 2004; *Medicare Drug Card Prices Remain High*, Washington, D.C., June 2004.

[64] For example, see Antos, Joseph and Ximena Pinell, *Private Discounts, Public Subsidies. How the Medicare Prescription Drug Discount Card Really Works*, The AEI Press, Washington, D.C., June,

beneficiary who either does not qualify for TA or fails to apply for it.[65] CMS itself has generated almost weekly reporting of how the Medicare-approved drug card programs are faring on the pricing front and Administration officials have asserted that competition among the Medicare-approved card programs will drive prices steadily downward, gradually enhancing the value of a card to the beneficiary.[66]

While proponents of the discount card program have found from their analyses that beneficiaries stand to save significant amounts of money using the discount cards, program critics have found that beneficiaries could do just as well or better buying their drugs from Drugstore.Com or, better yet, through Canadian-based internet pharmacies. If a consensus exists at all, it is with regard to the TA program, where the savings for qualified beneficiaries are obvious because of the $600 annual government subsidies. Results from these conflicting studies are generally not comparable, however, because their authors have analyzed different sets of drugs, different areas of the country, different sources of retail or approximated retail prices (i.e., what the cash customer would pay), and different analytic techniques. All of these studies have had to be conducted without the benefit of having access to the underlying drug price database that makes up the Medicare.gov PDAP tool.[67]

The actual savings for any one beneficiary will depend on his or her ability and willingness to "maximize" the potential savings, which may require switching from brand to generic drugs, from one community pharmacy to another, or from a community pharmacy to mail order.

We too sought to determine whether the Medicare-approved discount cards were providing value in terms of providing savings to a beneficiary who would otherwise be paying the full retail price. Like everyone else, our inability to access the full underlying database for the discount card part of the PDAP limited the scope of the inquiry and, as such, our ability to generalize from our results. (See Appendix for a discussion of our methodology.) Because the PDAP's comparative pricing information is available only on a drug- and zip code-specific basis, it is not possible to do a comprehensive evaluation of the savings achievable using the various approved card programs. Moreover, the actual amount of savings achieved by any one beneficiary will depend on his or her ability and willingness to "maximize" the potential savings, which may require switching from brand to generic drugs, from one community pharmacy to another, or from a community pharmacy to mail order. Nor is it certain that the same beneficiary could not have achieved the same savings by using some of the commercial discount cards that were being heavily marketed prior to the implementation of the Medicare discount card program.

These cautions noted though, the results of our pricing analysis are consistent with what some card program proponents have said: at least some of the cards do deliver good value when compared with the retail prices paid by cash customers. As indicated above, for

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2004; Centers for Medicare & Medicaid Services, *Medicare-approved Drug Discount Cards Provide Additional Savings to Low-Income Medicare Beneficiaries*, Washington, D.C. May 19, 2004.

[65] Health Care Leadership Council, *Medicare Prescription Drug Discount Cards. Immediate Savings for Seniors*, analysis prepared by the Lewin Group, May 2004. http://www.hlc.org/html/medicare.html

[66] For example, see Centers for Medicare & Medicaid Services, *Medicare-approved Prescription Drug Discount Cards Provide Drug Prices Significantly Below Average Paid by Americans*, May 6, 2004, http://www.cms.hhs.gov/medicarereform/drugcard/; Press Release, *Medicare-approved Prescription Drug Discount Cards Show Significant, Sustained Discounts*, May 28, 2004. http://www.cms.hhs.gov/default.asp?

[67] CMS will not provide the data base on the grounds that it includes proprietary information. Personal communication with CMS, May 17, 2004.

beneficiaries with TA, there is no question that some Medicare-approved discount cards are well worth having; even those that deliver little in price savings are better than going bare because the beneficiary pays no enrollment fee, gets the $600 annual credit applicable to all covered prescription drugs and not just those that are discounted, and – depending on the card -- may allow access to additional manufacturer savings on certain drugs once the credits are exhausted. Because of this, we focused our pricing analysis on savings for Medicare beneficiaries with no prescription drug coverage who do not qualify for TA.

Nonetheless, our inquiry also confirmed the findings of card program critics that the process of trying to use the Medicare.gov website to determine which card program(s) is the best buy is far from being user friendly and is likely to discourage many beneficiaries or even their more computer-savvy helpers. We spent countless hours trying to produce consistent and meaningful results, especially in the first few weeks that card-specific pricing data were available from the Medicare.gov PDAP website. To the credit of CMS, website improvements have made the PDAP steadily more reliable and user friendly. And like some card program critics who have doubted the likelihood of continuously declining prices, we found that prices have remained relatively stable. The details on our specific findings follow.

We first compare prices for ten specific drugs using a sample of seven approved discount cards with retail prices that would be paid by a beneficiary paying full retail prices. We then examine the cost implications of using various discount cards for four hypothetical beneficiaries. We further compare the implications for each individual if they lived in an urban versus a rural area of the country.

The process of trying to use the Medicare.gov website to determine which card program(s) is the best buy is far from being user friendly and is likely to discourage many beneficiaries or even their more computer-savvy helpers.

Do Medicare-Approved Discount Cards Save Beneficiaries Money Compared with Retail Prices?

We tracked the pricing on a weekly basis for a set of 10 drugs commonly prescribed for Medicare beneficiaries and seven Medicare-approved discount card programs over the period May 10 and June 28, 2004, ultimately eliminating the first two weeks of this period because of concerns about data reliability. We compared these prices to retail prices reported by the Maryland Attorney General's "Prescription Drug Price Finder," which tracks prices paid by cash customers for the 25 most commonly used drugs in Maryland. (See Appendix for an explanation of the Price Finder as well as our rationale for the selected drugs and card programs.)

We found that all seven of our selected card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG). Table 4 (on the following page) summarizes the range of savings provided by the seven card programs. A beneficiary purchasing any one of the 10 drugs sampled would save between 8% and 61% for a drug, depending on the specific drug, card program, and location of the pharmacy. Savings on brand name products were less in terms of percentages than for generics, but more in actual dollars. For example, an enrollee in one of the seven card programs in Baltimore ("urban") would pay between $159.41 and $166.05 at a network pharmacy for a 30-day supply of

We found that all seven of our selected card programs had prices that were significantly less than those reported by the Maryland Attorney General (AG).

Celebrex, compared to the median Maryland AG retail price of $198.99, for a 17% to 20% savings. An enrollee would pay between $4.27 and $6.45 for the generic drug furosemide at a card program network pharmacy, compared to the median Maryland AG retail price of $10.89, for a savings of between 41% and 61%.

Savings on brand name products were less in terms of percentages than for generics, but more in actual dollars.

Because the rural pharmacy prices reported to the Maryland AG are generally lower than those reported for the Baltimore zip codes, the percentage savings in the rural area are slightly less than in the urban area (card programs are required to report the highest price an enrollee will pay for a drug using their card, so although the price might be lower in some pharmacies, there was no way for us to include such differences in our analysis).

Table 4. Savings for Selected Drugs and Selected Card Programs Compared with Retail Prices in Two Maryland Areas

Drug Name	Brand or Generic	Maryland AG Median Price (Urban)	% Savings (Urban Retail*)	Maryland AG Median Price (Rural)	% Savings (Rural Retail**)	% Savings (Urban Mail order***)
Celebrex	Brand	$198.99	17-20%	$198.99	17-20%	28%
Fosamax	Brand	$87.49	17-28%	$80.63	8-21%	33%
Furosemide	Generic	$10.89	41-61%	$9.99	35-57%	81%
Hydrochlorothiazide	Generic	$8.87	38-54%	$6.33	13-36%	89%
Lipitor	Brand	$85.99	18-21%	$78.03	9-13%	30%
Norvasc	Brand	$76.99	19-22%	$76.84	18-22%	31%
Plavix	Brand	$147.12	17-22%	$155.60	21-26%	28%
Premarin	Brand	$36.99	12-26%	$36.43	10-25%	36%
Toprol XL	Brand	$34.99	31-39%	$31.21	23-31%	46%
Xalatan	Brand	$69.27	22-25%	$64.30	16-20%	34%
Total Price (10 Drugs)		$757.59	19-24%	$738.34	17-22%	27-32%

* Savings off of highest and lowest prices for seven selected Medicare discount card programs compared to the median Maryland Attorney General reported price for Baltimore zip codes 21201, 21202, and 21211.
** Savings off of highest and lowest prices for seven selected Medicare discount card programs compared to the median Maryland Attorney General reported price for Maryland zip codes 21811, 21842, 21851, and 21863.
***Mail order price for a 90 day supply from the selected card with the lowest mail order price was compared to three times the Maryland Attorney General reported price for a 30 day supply in the Baltimore area.

Six of the seven discount card programs studied offered a mail order option, and all six of the programs provide lower prices for each of the 10 drugs through mail order. Most of the card sponsors require that a minimum 90-day supply be filled through mail order, instead of the 30-day supply that can be obtained at the retail pharmacy, therefore making mail order primarily an option for established maintenance medications that are taken over long periods of time. Using the mail order options would provide significantly greater savings relative to full retail prices for our sample of drugs, providing savings of 23% to 89%, again depending on the product, the card program, and location. For example,

Using the mail order options would provide significantly greater savings relative to full retail prices for our sample of drugs, providing savings of 23% to 89%, again depending on the product, the card program, and location.

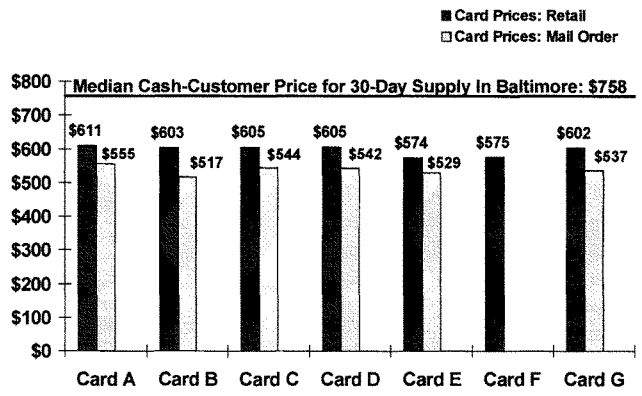
an enrollee could increase their savings on Celebrex to as much as 28% by using mail order, instead of the 17% to 20% savings that are available by purchasing from one of the seven card programs' network pharmacies.

Because prices and savings varied so much among the seven card programs for the ten drugs, we also analyzed the total price for the basket of all ten drugs, recognizing that our basket of 10 drugs is unlikely to be taken by one person. For the week of June 28, 2004, a beneficiary living in Baltimore electing the discount card with the lowest prices would have paid about $184 (24%) less than the full retail price for a 30-day supply ($758). Using the card with the highest prices, the beneficiary would have paid about $147 (19%) less. Overall, in terms of aggregate prices, the prices for the card programs were 19% to 24% lower than the aggregate of the median prices reported by the Maryland AG for the Baltimore area, and 17% to 22% less in the rural Maryland area. Mail order savings for the aggregate of the ten drugs when compared to the median Baltimore prices ranged from 27% to 32%. (See Figure 5. To allow comparisons, prices for mail order were adjusted to 30-day supplies.)

In terms of aggregate prices, the prices for the card programs were 19% to 24% lower than the aggregate of the median prices reported by the Maryland AG for the Baltimore area, and 17% to 22% less in the rural Maryland area.

Figure 5

Comparison Of Medicare-Approved Drug Discount Cards And Cash-Customer Prices



NOTES: Prices for a basket of 10 commonly prescribed drugs for Medicare-age population. Cash-customer prices reported by Maryland Attorney General. For purposes of comparison, mail order prices were adjusted to reflect a 30-day supply. Card F does not offer mail order.

In sum, our analysis shows meaningful savings for a subset of drugs and a subset of cards, compared to retail drug prices in two areas within one state. However, as others have noted, while these discounts do lower prescription drug costs, beneficiaries continue to face significant drug expenses. We do not know the extent to which the retail prices in Maryland are indicative of retail prices in other areas and states. Moreover, we cannot generalize about whether the same level of savings would be available for other drugs, in other areas of the country, and for the other Medicare-approved discount card programs. As indicated above, the prices reported by the card programs are their highest prices. Some of their participating pharmacies could offer lower prices, and thus produce greater savings to enrollees.

While there is a clear price advantage to mail order through one of the discount card programs compared to purchasing drugs at retail prices from a community pharmacy, we wanted to test how these mail order prices compared to companies that offer pharmacy mail order to the general public. To do this, we obtained prices for the same ten drugs from Costco and Drugstore.com. Figure 6 (on the following page) shows the prices for a 90-day supply of the basket of 10 drugs for our sample card programs with the lowest and highest prices compared to Costco and Drugstore.com.[68]

The Drugstore.com aggregate price was about 5% higher than the lowest priced card, but about 2% less than the highest priced card.

All of these six sample card programs had prices less than those offered by Costco for the 90-day supply of the 10 drugs ($1,745) ranging from 5% less for the card with the highest mail order prices ($1,664) compared to 11% for the card with the lowest mail prices ($1,552). Drugstore.com, however, was competitive with the six cards. The Drugstore.com aggregate price ($1,624) was about 5% higher than the lowest priced card, but about 2% less than the highest priced card. Drugstore.com is advertising that it accepts most of the Medicare discount cards and that its everyday prices are competitive with Medicare card prices at 20% to 30% off retail. We do not know if Drugstore.com lowered its prices as a competitive response to the Medicare discount card program or whether it offered this level of discounts before the card program was launched.

Does Choice of Discount Card Make a Difference?

We also sought to determine how the seven selected Medicare-approved discount cards compared with one another. To do this, for one urban location (Baltimore City, 21211) and one rural one (Ellsworth, Kansas, 67439), we tracked prescriptions for four hypothetical beneficiaries with varying prescription drug needs: (1) Mr. Miller, a 50 year-old disabled man; (2) Mrs. Hunt, a 65 year-old healthy woman; (3) Mrs. Fox, an 80 year-old frail woman; and (4) Mrs. Roy, an 82 year-old frail woman. Information on the rationale and methodology for developing these hypothetical beneficiaries is provided in the Appendix. Also presented in the Appendix is the list of the prescriptions taken by each of these beneficiaries.

Drug price results were tracked from the PDAP for eight weeks (May 10 through June 28, 2004) for the seven selected card programs. In addition, we determined which of all the general card program(s) (national or regional) displayed the lowest aggregate price for each of the four beneficiaries' basket of drugs (this almost always turned out to be a card that was not one of our seven selected programs). For the last week, we also tracked which card

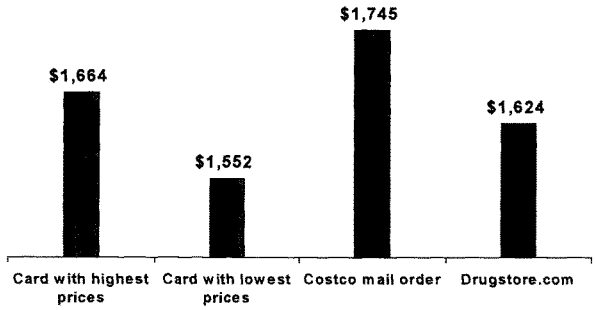
[68] One of the seven card programs does not have a mail order option.

program out of all available card options had the highest aggregate price. Pricing data for the weeks of May 10 and May 17 were eliminated because of concerns about their reliability.

Figure 6

Prices Offered By Medicare-Approved Drug Discount Cards Compared With Costco Mail Order And Drugstore.com

Mail Order Prices (90-Day Supply)



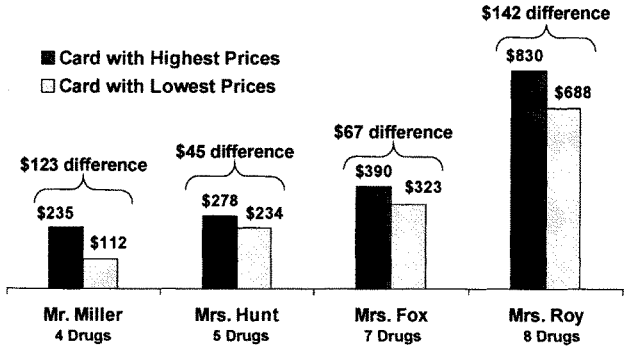
NOTES: Prices for a basket of 10 commonly prescribed drugs for Medicare-age population. Costco price assumes purchaser has a Costco membership; drugs are available without membership for an additional 5%.

Our analysis illustrates that the choice of a card program may have significant financial implications for a Medicare beneficiary, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order). Figure 7 on the following page shows, for the four individuals in our study, the difference between the highest and lowest price of their basket of drugs among all of the card programs available to them (that had prices available for all of their drugs). We compared prices for each basket with brand and generics, when available, at the retail pharmacy and through mail order. Where prices varied by pharmacy within a program, we used the price at the extreme, i.e., the lowest priced pharmacy for the lowest cost card and the highest pharmacy price for the highest priced card. For three of our individuals, the highest card was 19% to 21% more than the lowest priced card at the retail pharmacy, or a cost to the beneficiary of $45 to $142 a month. For Mr. Miller, the highest priced card was $123 more (110%) than the lowest priced card. There was an even greater difference when the cards with the lowest and highest mail order prices were compared for these individuals. The cards with the highest mail order prices were $174 to $406 (26% to 36%) higher for a 90 day supply than the lowest priced mail order cards for the three women; the price difference for Mr. Miller was $646 (159%) for a 90 day supply.

The choice of a card program may have significant financial implications for a Medicare beneficiary, based on their drug regimen, where they live, and how they prefer to purchase their drugs (pharmacy or mail order).

Figure 7

Difference Between Highest And Lowest Drug Prices Offered By Medicare-Approved Drug Discount Cards
(30-Day Supply)



SOURCE: Medicare.gov, June 28, 2004.
NOTES: Retail prices for 30 day supply of each patient's basket of brand and generic drugs (if available) from pharmacies within 2.25 miles of zip code 21211 in Baltimore, MD.

Drug-specific prices. The prices for individual drugs in each of the four hypothetical beneficiaries' baskets did change some for some cards. For example, the price of Prozac (used by Mr. Miller) increased by about 5% for all of the selected cards as well as for the lowest priced of all cards, although the week during which the price increase occurred varied. Subsequent inquiry would be needed to determine whether this price change is due to changes in manufacturer prices or other factors.

Savings on Generics. We also looked at the implications of substituting generic alternatives when available. Some of our individuals were already taking generic products. Therefore, we looked at the implications of substitution for the brand drugs that they were taking. Only two of our four individuals were taking brand drugs for which there were lower cost generic alternatives.

Our analysis shows that these individuals would clearly save by electing the generic option, but the amount of savings would vary by drug, card, zip code, and whether purchased from a retail pharmacy or through mail order. Mr. Miller, living in Baltimore, using the generics for Glucophage (metformin) and Prozac (fluoxetine) could save anywhere from about $125 to $195 for a 30-day supply, depending on which card program he selected. Mrs. Fox, living in Baltimore, would also experience a savings by asking for generic prices. Her doctor had already prescribed a generic blood pressure medication (Benazelpril), and the only other drug in her basket for which a generic substitution is possible is Coumadin (Jentoven). The

maximum savings for Mrs. Fox would be about $40 using the best card's retail pharmacy price. Both Mr. Miller and Mrs. Fox would experience similar levels of savings from the substitution of generics through mail order. It should be noted that our analysis of generic prices was hampered by problems with the PDAP data. Sometimes the PDAP would give prices for baskets of drugs where generic alternatives were factored in incorrectly. Improvements have now been made so the pricing differences are clearer, although occasional glitches continue.[69]

Have Discounted Prices Changed Over Time?

On May 14, 2004, CMS issued a press release indicating that after the first week of posting prices on the Medicare.gov website, approved card programs had lowered their average discounted prices by approximately 11.5% for brand name drugs and 12.5% for generic drugs in selected zip code areas, "lowering their prices to become more competitive".[70] Our analysis did not show that prices were continuously dropping.

Our analysis of the selected drugs and selected card programs showed that while there were a few changes up and down for selected products and cards, overall prices remained relatively flat.

Because of the large amount of data errors we discovered in tracking prices at the beginning of the program in early-mid May, we were unable to draw any conclusions about price changes during this period. However, over the subsequent six weeks (May 24-June 28), our analysis of the selected drugs and selected card programs showed that while there were a few changes up and down for selected products and cards, overall prices remained relatively flat. Figure 8 on the following page displays the price variation for the basket of seven drugs taken by Mrs. Roy over the six week period for the seven selected card programs. For example, using Card B, the aggregate price would have increased by about $7.00 over the six-week period; with Card G, it would have increased by about $2.20. Using Card F, however, it would have declined by about $13.80. Results for the other three hypothetical individuals were similar. No card's aggregate prices changed more than 4%.

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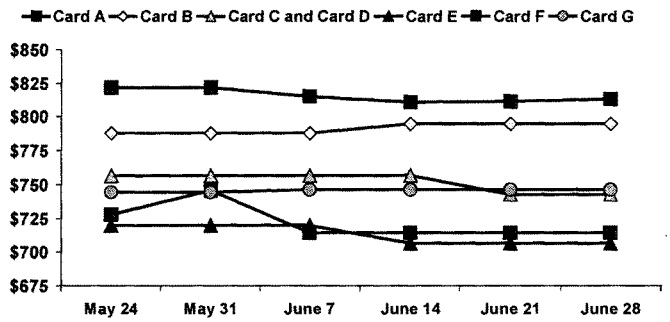
[69] Improvements could still be made, however. Many users of Medicare.gov's PDAP will not know whether a specific drug is a brand or generic. If the user initially enters a generic, and still requests generic alternatives, the software does not identify the generic as such. The price of the generic drug is displayed under the "brand" column.

[70] CMS Press Release, *Medicare Drug Discount Cards Continue to Drop Prices and Offer Better Savings*, May 14, 2004 Press release. Cms.hhs.gov/media/press/release.asp?Counter=1049.

Figure 8

Prices Offered Over Time By Seven Selected Medicare-Approved Drug Discount Cards

Illustrative Example for Mrs. Roy



NOTES: Prices reflect mid-point in range of prices reported on Medicare.gov. Card A missing price data for June 7 and June 21, 2004; midpoint estimates used for missing weeks. Card C and Card D reported the same prices for this patient's basket of 8 drugs.

CONCLUDING OBSERVATIONS

Our report documents key elements of the Medicare discount card program and the transitional assistance program. While we have observed a number of implementation challenges facing CMS and card sponsors, for the most part they reflect the relatively short time for implementation and the significant administrative and outreach tasks associated with these programs. We have noted that CMS has continued to make improvements in the quality, reliability, and accessibility of information posted to its website. The sheer volume of information, however, is likely to be overwhelming for many beneficiaries and those who assist them.

Critical to a successful implementation of the discount card program is getting clear, consistent and accessible information to beneficiaries and those agencies and individuals on whom beneficiaries rely for assistance and advice. Educating beneficiaries has proved to be a significant undertaking because of the large number of card programs, the challenge of communicating with over 40 million individuals, and the lack of knowledge about this new program. Despite a substantial investment by CMS in decision support tools, reports of beneficiary frustration and confusion have been widespread. And while the websites and brochures of the individual discount card programs contain some common elements, key program features such as drug lists (formularies), pharmacy networks, the availability of

additional manufacturer discounts, and the description of the available discounts vary and may be inaccurate

Our effort to determine the value of the card program in terms of savings for 10 commonly prescribed drugs showed that at least some cards do provide value compared to full retail prices. We also found that choice of card program can make a significant difference in the value to an individual beneficiary. The range of pricing differences for our four hypothetical Medicare beneficiaries was large enough to create significant financial implications based on card choice. Finally, we did not observe notable changes in reported prices over our study period of six weeks, which excluded the initial two weeks of pricing data because of concern about its reliability. It will be interesting to see what happens to prices before the annual open election period in November when enrollees will have the opportunity to change enrollment from one approved discount card to another.

Overall, the experience to date with implementation of the discount card program suggests several important implications for putting the new Medicare Part D drug benefit in place in 2006. First, while choice helps to ensure that beneficiaries can find a plan best suited to their individual needs, excessive choice produces confusion, and may discourage enrollment. The tradeoff of too many choices may be indecision, which may be a major reason why so few beneficiaries have signed up directly for the cards. The majority of the 3.9 million enrollees so far have been auto-enrolled by their Medicare Advantage plans (2.3 million) and their State Pharmacy Assistance Programs.

Second, managing beneficiary education is especially challenging and costly for the Medicare population because of the need to use multiple means of disseminating complex information, including the availability of trained counselors to provide individual support. The administrative and oversight investment required to assure the integrity of the discount card program will likely be the same or greater for the new Medicare drug benefit. Although the internet is a useful tool for beneficiary education – and holds out great possibilities for increased drug pricing transparency -- the need for more accessible "face-to-face" beneficiary education cannot be underestimated. Most beneficiaries are not comfortable using the internet; and even their helpers are likely to find the web-based information more perplexing than helpful. Lessons from the card program experience could help to make the transition to a Medicare drug benefit more beneficiary friendly.

APPENDIX – PRICING ANALYSIS METHODOLOGY

In response to the Kaiser Family Foundation's interest in a "first look" analysis of the Medicare Discount Card and Transitional Assistance Program, we requested from the Centers for Medicare and Medicaid Services (CMS) the data base that underlies the Medicare-approved discount card portion of the Prescription Drug and Other Assistance Programs (PDAP) tool, located on the Medicare.gov website. Because CMS considers the database proprietary, this request was not approved. As a result, we were limited to using the publicly available PDAP to do our pricing analysis.

Ideally we would have reviewed all drug prices for all Medicare-approved discount card programs. However, because the PDAP tool is designed to produce data for specific individuals, obtaining summary data is extremely cumbersome and time consuming. As a result, we were only able to examine a small subset of drugs for a limited number of zip codes. The weakness of this approach was that it limited our ability to generalize our findings; its strength is that we were able to experience the Medicare.gov website and the PDAP in the same way as beneficiaries and others working to assist them.

In doing a pricing analysis of the Medicare-approved discount cards, we hoped to answer the following major questions: Would prescription drug prices be less expensive using the Medicare cards than if the beneficiary paid full retail prices? Would the drug prices achieved by the different card options change over time? Would there be, as some have predicted, a significant price reduction over time as the Medicare-approved discount card program sponsors competed for enrollees? How would the discount cards compare with one another? Would one or more cards prove to deliver better discounts than the others?

Our first set of questions required us to identify a practical measure of the full retail price – a benchmark against which to compare the prices obtainable using the discount cards. Some researchers have used the Average Wholesale Price (AWP) for this purpose. However, the AWP is not a good measure of what cash customers – those paying the full retail price -- actually pay. (They may, in fact, pay AWP plus an additional amount.)[71] Other researchers have surveyed pharmacies in specific areas for the prices on specific drugs, a labor intensive approach if the goal is to obtain prices from more than a few areas.

For our source of retail prices, we elected to use the Maryland Attorney General's (AG's) "Prescription Drug Price Finder."[72] This web-based tool was recently established to enable residents of Maryland to comparison shop among Maryland pharmacies. It provides the usual and customary price, described as comparable to the prices paid by cash-customers without insurance.[73] The strength and dosage of each drug are also presented. Prices initially posted were surveyed for the period March 1, 2004 through April 1, 2004. The website was subsequently updated to reflect prices through May 31, 2004.

A major limitation of the Maryland AG's Price Finder is that it only provides prices for 25 of the most commonly used drugs in Maryland, as reported by the state's Medicaid program.

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[71] U.S. Department of Health and Human Services, *Prescription Drug Coverage, Spending, Utilization, and Prices*, Report to the President, Washington, April 2000, chapter 3.
[72] www.oag.state.md.us/drugprices/
[73] Prices are reported to the state "by each pharmacy each time a pharmacy filled a prescription for a drug in the survey. "www.oag.state.md.us/drugprices/

Obviously, another limitation is that prices are available only for Maryland and are updated on a less frequent basis than the Medicare.gov PDAP.

To obtain a set of drugs for which comparable prices (i.e., the same drug, strength, and dosage) could be tracked for both the Medicare discount cards and Maryland pharmacies, we selected the first ten drugs (including strength and quantity per month) that appeared on both the Maryland AG's Price Finder and on AARP's list of the top 250 brand or generic prescription drugs. The AARP list is based on the number of prescriptions adjudicated by the AARP Pharmacy Service in 2003. Individuals who use this service (i.e., AARP members) are ages 50 and older (including, therefore, both Medicare disabled and 65 and older Medicare beneficiaries). The AARP list reflects utilization by about two million individuals, and includes both brand and generic drugs.[74] The resulting set of drugs used for our price tracking is displayed in Table A-1.

Table A-1. List of Prescription Drugs in the Pricing Analysis

Drug	Strength	30-day supply
Celebrex (brand)	200 mg	60
Fosamax (brand)	70 mg	4 (1 per week)
Furosemide (generic)	40 mg	30
Hydrochlorothiazide (generic)	25 mg	30
Lipitor (brand)	10 mg	30
Norvasc (brand)	10 mg	30
Plavix (brand)	75 mg	30
Premarin (brand)	0.625 mg	30
Toprol XL (brand)	50 mg	30
Xalatan (brand)	0.01% solution	2.5 ml

Second, we needed to select a manageable number of Medicare-approved discount cards for which we could track prices. As noted above, monitoring prices for all of the approved general card programs was not practicable because of the PDAP's design. Consequently, we selected a set of cards that appeared to meet a few basic criteria (based on early monitoring of the PDAP and individual card program websites). Cards were selected if they were: (1) general national cards, (2) had their own active and relatively complete websites; (3) appeared to provide discounts on all of the drugs needed by our prototype beneficiaries; and (4) more broadly seemed to provide discounts on most if not all covered drugs (as defined by the MMA for the card program). Seven card programs met these criteria:

- AARP Prescription Discount Card
- aClaim Rx Savings Club
- Aetna Rx Savings Card
- ArgusRx
- Preferred Prescription Discount Card
- Rx Savings distributed by Reader's Digest, and
- ScriptSave Premier.[75]

We were also interested in comparing Medicare discount card and Maryland retail pharmacy prices to the prices available using major U.S. based internet pharmacies that sell to the

[74] Personal communication with staff of AARP, May 7, 2004.
[75] We later determined that ScriptSave Premier and Aetna, which use the same PBM/TPA, and quoted the same retail pharmacy prices, although different mail order prices.

general public. For this purpose, we used Costco.com and Drugstore.com. Both provide drug-specific pricing on relatively user friendly websites. For Costco, we needed to adjust the dosage units for a few of the selected drugs so that they were the same as used for the Maryland Price Finder and the PDAP.

Third, we needed to select areas for which we would track the discount card and Maryland AG prices. Like the PDAP, the Maryland Prescription Drug Price Finder displays drug-specific prices by pharmacy within a specific zip code. We selected one urban zip code (Baltimore City, 21211) and one rural one (Pocomoke, Maryland 21851) to track the Maryland retail prices. Because Maryland AG prices were not available for all drugs for the two selected zip codes,[76] we had to expand the urban area to two additional zip codes (21201 and 21202) and the rural one to three more zip codes (21811, 21842, and 21863). For the seven selected Medicare-approved discount cards, we tracked prices in urban Baltimore (21211) and Pocomoke Maryland (21851). We did not, however, confirm that the selected pharmacies actually accepted each of the seven discount cards.[77]

To compare the prices quoted by the different Medicare discount cards, we identified four prototype Medicare beneficiaries (one pre-65 disabled and three seniors) and collected information on the specific drugs that they would typically use for their health conditions. The specific drugs for the four prototype beneficiaries were suggested by a previous study.[78] (See Table A-2 on the following page.) Because we also wanted to check whether geography affected the availability of card programs, pricing and pharmacy access, we located each of these four beneficiaries in an urban area (Baltimore, Maryland 21211) and a rural one (Ellsworth, Kansas 67439).

With these established data sources, selected discount cards, prototype beneficiaries, and target locations, we began our data tracking process. We tracked prices from the Medicare.gov PDAP for each of the seven selected discount cards as well as the prices shown for whichever of all available general national and regional card(s) displayed the lowest prices. We did this for the four prototype beneficiaries' specific basket of drugs, collecting both the bundled and drug-specific prices. In addition, we obtained the card prices for generic alternatives, if any and mail order prices, if available. For the last week of our tracking, June 28, we also recorded which Medicare card program(s) of all available cards in the beneficiary's area quoted the highest price. This too was done for the generic alternatives as well as for mail order options.

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[76] Because during its survey period, not all pharmacies fill prescriptions for all 25 drugs, there are a significant number of drugs for which prices are not available for a given pharmacy.

[77] According to an investigation by the minority staff of the House Committee on Government Reform, "numerous pharmacies listed on the [Medicare] website are listed as participating members of drug card networks when, in fact, they are not participants." Letter from Representatives Henry Waxman and Louse Slaughter to Secretary Tommy Thompson, July 6, 2004, obtained from www.InsideHealthPolicy.Com, July 9, 2004.

[78] Synder, Rani E., Thomas Rice and Michelle Kitchman, The Cost Implications of Health Plan Options for People on Medicare, Kaiser Family Foundation, January, 2003, www.kff.org/medicare/upload/14361_1.pdf

Table A-2. Prescription Drugs for Four Hypothetical Medicare Beneficiaries		
Disabled male (Mr. Miller)	**Strength & Dosage Per Day (pd)**	**Common Therapeutic Purpose**
Glipizide	20 mg, 1pd	Used to treat diabetes mellitus type II.
Glucophage/metforman	500 mg, 1 pd	Used to treat type II diabetes.
Macrodantin nitrofuranoin	100 mg, 1 pd	Antibiotic used to treat cystitis and other urinary tract infections.
Prozac/Fluoxetine	40 mg, 1 pd	Antidepressant. Also used to help people with obsessive compulsive disorder, eating disorders, panic disorder, post-traumatic stress.
Healthy female 65 (Mrs. Hunt)		
Benazelpril	20 mg, 1 pd	Used to lower blood pressure (hypertension).
Lipitor	20 mg, 1 pd	Used to lower blood cholesterol.
Levothyroxine	100 mcg, 1 pd	Used to treat thyroid problems such as hypothyroidism.
Fosamax	10 mg, 1pd	Reduces amount of calcium lost from bones; increases the density of bones. Used to treat patients with Paget's disease or postmenopausal osteoporosis.
Prempro	.45-1.5 tabs/day	Used to relieve symptoms of the menopause and also help to prevent the onset of osteoporosis.
Frail female 80 (Mrs. Fox)		
Benazelpril	20 mg, 1 pd	Used to lower blood pressure (hypertension).
Lopressor	50 mg, 1 pd	Used to lower high blood pressure (hypertension). Generic tablets are available, but in extended-release
Glyburide	2.5mg, 1pd	Used to treat type II diabetes mellitus.
Aricept	10 mg, 1 pd	Used to treat the symptoms associated with Alzheimer's disease or dementia.
Celexa	20 mg, 1pd	Used to treat depression and other related problems.
Coumadin/Warfarin sodium	3 mg, 1pd	An anticoagulant, helps to treat/prevent clots in veins, arteries, lungs, or heart.
Frail Female, 82, restricted (Mrs. Roy)		
Celebrex	200 mg, 2 pd	Used to relieve some symptoms caused by arthritis, such as inflammation, swelling, stiffness, and joint pain.
Diovan/HCT	80/12.5 tabs, 1 pd	Used to lower blood pressure.
Prevacid DR	30 mg, 2pd	Prevents the production of acid in the stomach, reducing symptoms/preventing injury to the esophagus, stomach, or intestines. Used to treat active ulcers.
Zoloft	100 mg, 1pd	Antidepressant; also used to help people with obsessive compulsive disorder, panic attacks, post-trauma stress, or social anxiety.
Zocor	40 mg, 2pd	Used to help lower blood cholesterol.
Furosemide	40 mg, 1pd	Diuretic, used to treat high blood pressure (hypertension) and to reduce swelling and water retention caused by heart, liver, or kidney disease.
Spironolactone	25mg, 1pd	A diuretic, used to treat hypertension without depleting potassium.

The Maryland AG's Price Finder and the Medicare.gov PDAP were checked each week for the eight weeks beginning May 10, 2004 and ending June 28, 2004. We excluded the first week for which the PDAP had data, a time when a variety of glitches and data errors suggested that the results might not be reliable. We ultimately decided also to exclude the

weeks of May 10 and 17 from our analysis because of the persistence of website problems. For those two weeks, data were especially spotty, with individual drug and bundled price data unavailable for some cards and incorrect or incomplete bundled price range data (prices for generics were especially problematic). Although price changes were only supposed to occur weekly (new prices are posted each Monday morning at 12:01 AM), prices for four of our selected card programs frequently experienced midweek price changes or showed miscalculated bundled prices if they were there at all. While some of these problems continued for several additional weeks, price data were overall more stable after the week of May 17. Throughout the study period, however, there were weeks for which prices for some cards were unavailable because they did not appear on the PDAP.[79]

Using these PDAP, Maryland AG, and internet pharmacy data, we performed the analyses needed to address the research questions identified above. The analyses presented in the report comparing the prices for the subset of ten drugs to the Maryland AG's retail prices, as well as the comparisons of prices among the seven selected cards for the prototypical individuals, are based on prices obtained in the last week of our data collection.

To assess discount card price fluctuations over time, we analyzed the PDAP prices both for the ten selected drugs and the individuals' basket of drugs for each of the six weeks, May 24 through June 28. As we report using the example of Mrs. Roy, there were small price variations for specific drugs and specific cards, both up and down, but there was no consistent downward trend.

[79] For those weeks, website users were instructed that "Currently no information is available. Please check back later." This problem persisted throughout the study period.

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Mr. FIRMAN. Good. Thank you.

Now, we are going to open this up a little bit, and I was writing down questions for all of you, so I am going to ask a couple of the first questions, but I would just like to think of this as having a conversation over the dinner table, and at least in my family, we all interrupt each other, so, when we are talking, so you do not need to wait for me to follow on the next person. If it gets out of hand, I will step in.

But I will actually, for the first couple of questions, they will come from me, because one of the things that the field of health services research, and I guess this is what this is, of an order, is seeing whether when one has multiple studies and whether they produce consistent results. We have heard a lot of numbers here, and I really want to see to the extent to which results were and were not consistent.

So I have two questions I want to ask each of you. I just want to go down the row so that we can see the similarities and the differences in the answers. The first question is, for a non-low income—this is for a middle class person who does not qualify for transitional assistance, who buys their drugs at the drug store, which is what most people want to do, and they do not want to go somewhere else, what were the average savings in your study for a person who uses the card? Do you guys need a little moment to do your calculations here?

Ms. JAMES. OK; I think I just——

Mr. FIRMAN. OK; I just want to hear one, two, three, four, so we can all synthesize this and see whether we have the same numbers. The savings?

Ms. JAMES. The retail?

Mr. FIRMAN. Retail.

Ms. JAMES [continuing]. The number that we had was 19 to 24 percent.

Mr. FIRMAN. Nineteen to 24 percent.

Bob.

Mr. HELMS. Well, I need a calculator, but it went from $2,073, which is the full retail, for the Medicare retail down to $495, and we did calculate that it was down—the mail order was $388.

Mr. FIRMAN. Let me interrupt you. OK; you are going to go back and do your calculation only because——

Ms. JAMES. I think it is apples and oranges, though.

Mr. FIRMAN. OK; We have got 19 to 22 percent; is that what I heard, Mary?

Ms. JAMES. Nineteen to 24.

Mr. FIRMAN. I am sorry; Julie.

Yes, Mary?

Ms. GREALY. All right; I will just give you the simple national average, 20 percent.

Mr. FIRMAN. OK; 20 percent.

Sharman.

Ms. STEPHENS. I am probably going to make your life difficult, but one of the things, and I have sort of——

Mr. FIRMAN. OK.

Ms. STEPHENS [continuing]. I have looked actually across all the studies, and how you think about this and one of the reasons you

see the numbers, you see and why you are getting different numbers.

Mr. FIRMAN. We will get into why they are different later. But what is the number?

Ms. STEPHENS. Well, what you saw in ours for retail, dealing with predominantly brand name drugs, is that we are running between 12 and 21 percent. Then, if you go to generics, you see a slightly different picture.

Mr. FIRMAN. OK.

Ms. STEPHENS. If you look at individual drugs versus baskets——

Mr. FIRMAN. Right, so people have a mix of drugs. So we have heard 12 and 21, 19 and 22.

Ms. GREALY. Twenty.

Mr. FIRMAN. Twenty.

OK; so——

Six to 25; good, OK. Well, that is—we are seeing some consistency, and they are all savings, and they are all—OK, now, a little harder one, for low-income Medicare beneficiaries, again, I know I am making you do things that health services researchers do not do, but think of more of a lay person like me. I am in this situation. A low-income beneficiary, average range of savings.

Ms. JAMES. We did not look at that.

Mr. FIRMAN. OK. You are safe on that one, yes.

Ms. JAMES. For the $600 people, we did not look at that.

Mr. FIRMAN. OK; Sharman?

Ms. STEPHENS. OK; go ahead.

Ms. GREALY. No, I was just going to say, ours is up on the chart if you look, and I am trying to do the percent: 47.3 percent.

Mr. FIRMAN. OK; for——

Ms. STEPHENS. For low-income——

Mr. FIRMAN. Low-income.

Ms. STEPHENS [continuing]. Beneficiaries.

Mr. FIRMAN. We understand it is going to vary by the medications they take and different situations.

Ms. STEPHENS. Because we look at this in baskets, we come up with a range. So, we had anywhere from about 44 to 91 percent. Now, it also depends on what period of time with which you are working.

Mr. FIRMAN. So 44, in the forties, but a very substantial savings in both cases.

Mr. HELMS. Almost 80 percent.

Mr. FIRMAN. Almost 80 percent. So we are kind of hearing 40 to 80 percent or so for low-income beneficiaries. Thank you. That is helpful, and the fact that different people with different approaches or different all sorts of qualifications, I know each one of you would rather give me a bunch of footnotes on that answer. I really do appreciate that.

A second question that I have, and this is people, as I said, most people in our experience, and we have been talking to lots of beneficiaries, you can tell them all these things about savings and what they do, but the bottom line is what is going on at my drug store? I only want to buy medications at my drug store. So my question is to get these savings, are people going to have to—by and large,

can people get them at their drug stores, or are they going to have to go somewhere else to get the savings that we are talking about?

Ms. JAMES. Well, Jim, I think that——

Mr. FIRMAN. It is easy to ask the questions. You guys have got to figure out how to answer them.

Ms. JAMES. Well, I do think that one of the most helpful things to help you sort through all of the information on the Website, and Sharman can speak to this better than I can, but you can look by pharmacy. So if that is your starting point, if you want a particular pharmacy, you can start there and look at the cards and only compare the cards that accept that pharmacy.

Now, we found that many of the cards have very, very extensive networks, 50,000 pharmacies, participating.

Mr. FIRMAN. That is part of the question. These are pretty broad networks in the number of——

Ms. GREALY. Jim, we only looked at retail pharmacy. We did not do the mail order. So those savings percentages and numbers are just for that.

Ms. STEPHENS. I will say an unequivocal yes.

Mr. FIRMAN. OK; good for you.

Ms. STEPHENS. I can tell you, when we do these studies, I am pulling from the Website. My staff will confess to many early mornings getting up for the pull on Mondays. When we are doing this, we are doing it with ZIP Codes, and we are doing it with a local radius. So, these savings are in your locality, in your neighborhood, and as Julie said, "The Website has just recently been enhanced to make it even easier to look for your pharmacy, because we know it matters."

Mr. FIRMAN. Good.

Mr. HELMS. Can I, Sharman, do you have any evidence that there are any pharmacies out there that just refuse to participate?

Ms. STEPHENS. I have not looked at it, where I have taken a census of the pharmacies and seen if we do not have something, but we have quite extensive——

Mr. FIRMAN. I can tell you what we have heard through that. We have heard some concerns and some of the particularly independent, smaller, independent pharmacies have found it in some cases in rural areas, there have been some problems with pharmacists just having small shops, having difficulty with some of the arrangements. So at least, there have been some cases of people having some difficulty.

Mr. HELMS. But I think in our surveys, we have not found one.

Mr. FIRMAN. Well, there are consumers calling us who have.

Ms. JAMES. Actually, I have a family member in an assisted living facility, and I called the pharmacy to see who they were participating with, and they were not interested in participating with anything. So I do think in that case, that there are some cases——

Mr. HELMS. It is very rare, I think.

Mr. FIRMAN. Yes, but, OK——

Ms. STEPHENS. But the networks, I mean, when we look at the network files, they are pretty extensive.

Mr. FIRMAN. So the savings are real, and you can probably get it, some good savings at your drug store.

Ms. GREALY. Widely available.

Mr. FIRMAN. Widely available; good.

OK; another question that I had, and it relates to this. We have heard this thing about wraparounds and with the extra savings that come from that, and actually, I have some data. I would like to share—that we released earlier today. We did an analysis of about 20,000 people who had gone to our Website accesstobenefits in May and June, and we found that of the people eligible for transitional assistance, 83 percent of them were taking at least one of those wraparound drugs, medicines with the extra saving, and 50 percent were taking two or more wraparound drugs.

So our sense was that these wraparound savings in total were actually much more significant than $600, certainly, for people taking that, and I was just wondering whether, in the analyses that you had, whether you had some consistent types of findings of the power or the potential savings from these wraparounds.

Ms. JAMES. Well, I will just say that you can find out which of the cards are participating with—and I think when you are talking about wraparound, you are talking about the pharmaceutical companies that are offering additional assistance like flat fees for their products if you qualify. There are a number of the companies that are doing that, and you can find out which of them are associated with the various cards.

I know of at least one instance with one pharmaceutical company that actually changed and broadened its policy in order to be out there and reach more people.

Ms. STEPHENS. I will do a plug for the Website. One of the really new enhancements for the Website is that we are now calculating the savings, so that information is available to beneficiaries. It was quite extensive work to work with the card sponsors and the manufacturers to make sure we understood the arrangements so we could do the calculations. But now if you go to the website for the beneficiaries who are low-income and transitional assistance eligible, the website is calculating savings.

So for people who have been using the Website, there are some new features there.

Mr. FIRMAN. I want to say that is a really great enhancement to the site, and we, on our Website, also have a lot of emphasis on wraparounds because of the same reasons. They really do, I think, are something that our experience is consumers do not really know much about but——

Ms. GREALY. Jim, I was going to say, and not just for the Medicare population, but these are programs that have been out there, these patient assistance programs by the manufacturers that have not been well publicized. I think what is great about this program is it is not only bringing publicity to it just for this population but for other low-income populations as well, and I think also, the manufacturers have really enhanced the programs and made them much more accessible and easier to use.

Mr. FIRMAN. Well, you know, you made another important point. I do not believe in any of the studies that I heard, you were looking at the effect of company patient assistance programs which are different than the wraparound programs or the State pharmacy programs or the impact. Our analysis has shown that if people are eli-

gible for transitional assistance, 80 percent of those people are eligible also either for patient assistance programs or State programs.

Even if you look at people who are not eligible for TA but under 200 percent of poverty, about two-thirds of them are eligible for patient assistance programs, so that there are other savings beyond what you have talked about from some of these other benefits.

The next question I have—it is fun. I get to ask a couple, and then you have to——

Ms. GREALY. We have to think of one for you.

Mr. FIRMAN. I know. As you can tell, these are not scripted questions. I do not even know what I am going to ask, much less you guys.

One of the questions I have is that I remember maybe 2 years ago, before all of the Medicare laws came in, I saw several studies which showed that the prices within a community, from drugstore to drugstore, could vary by as much as 200 percent. You could be paying $100 for a drug in one store, and three blocks away, you could be paying $200, but there was no way to know about that.

I personally think that is one of the most amazing things about this whole price compare is now that you can look at numbers. So, my question is now that you guys have looked at the numbers, are the same variations still there? If I went onto Medicare.gov, and I put in a drug and the highest to the lowest, would I still find one being two times as expensive, or has the band of prices from the highest to the lowest narrowed to any significant extent?

Ms. STEPHENS. I do not know that we have looked at that. Are you asking from a pharmacy perspective or from a card perspective?

Mr. FIRMAN. From a price perspective; in other words, if I were—pharmacy A, and 2 years ago, pharmacy A could have been charging $200 for a drug, and pharmacy B could be charging $100 for the same drug, and that was not uncommon. The question is now, if I went and looked at, because of the necessity or the price compare, which has made prices transparent, is the range still there the same way? If I went onto Medicare.gov and entered in a drug, and I said, "You know, from highest to lowest," would I likely to see one being twice as expensive, or is it more like a 20 percent difference?

Ms. STEPHENS. I think in the Lewin study, you see this finding. I think Bob mentioned it as well. We do not see across the cards large variation in pricing. So, I think some of that is the feature of the program. So whether in pharmacies that are in a cash market phenomenon, the variation in pharmacy is changing, although it could be, I do not know. But within the card program for a given card sponsor, if you go across the country, which I think you all see, we did not see much difference for a given card sponsor.

Now, between card sponsors, there are pricing differences.

Mr. FIRMAN. But are they 100 or so, or are they much smaller?

Ms. STEPHENS. They narrowed over time.

Mr. FIRMAN. OK.

Ms. STEPHENS. They have narrowed.

Mr. FIRMAN. There was competition. So, in other words, if you—at one level, drugs are a commodity. Celebrex is Celebrex is Celebrex, and if I went from one gas station to another, I would

never see one for $1.98 and one for $4. You just would not see that kind of variation. Do we think that this price compare and transparency is having that kind of effect on medication?

Ms. GREALY. I think absolutely. I think as Sharman said, in our study, you can see that there is little geographic variation within a card. I think that is remarkable for the Medicare program, when you look at the variety of reimbursement levels and how disparate that is across different geographical markets, but this whole idea of the transparency, I think as Bob said, it is really going to drive the market competition and lower prices for everyone.

Mr. HELMS. Yes, we will have to wait for some definitive studies of this, but there have been a number of studies of local markets that found just what you are talking about, that there is a lot of dispersion, surprisingly, in the retail prices.

Mr. FIRMAN. Now or in the past?

Mr. HELMS. In the past. In local areas. But my point is the fact that you have got a place now that people can easily go look up the price and see what Medicare is charging, even if they are not eligible for Medicare, they can go shop around, and they have a reason to shop some more to find if the can get a better price.

With the publicity you are getting now from the Internet and about Canadian prices, it sends a signal to consumers that it will probably pay to search. But the other thing is that the retail market has been affected by a big growth in insurance coverage. That has taken away the incentives for the big majority of people who have a plan that covers prescriptions. There is not much reward for them for shopping around.

Ms. JAMES. Yes, but I do think it is important to know that the Medicare card prices are not the retail prices that they quote when you walk into the pharmacy, and so, there is no way to know right now anyway; I do not think anybody is looking at that. Although if you look at, for example, the data base that we used that Maryland puts out, those are the prices that the pharmacists will quote you if you walk in that have nothing to do with the Medicare discount card.

One of the things I wanted to point out that we did find was that prices in the urban areas were higher than in the rural pharmacies in Maryland. The discount card prices, however, are the same. So that actually meant that if you lived in the urban area, you were getting a bigger savings, because your retail prices are higher there.

Mr. HELMS. We found some of the same kind of urban-rural differences in Idaho recently.

Ms. GREALY. But I think Bob also made a very important point. Whenever we are talking about prices and prescription drugs, that many people have health insurance coverage that covers their prescription drug benefit. That means that in many instances, they have someone already negotiating lower prices on their behalf, and that is why you probably have fewer people who are out there doing that retail pharmacy by retail pharmacy comparison. Now, Medicare beneficiaries will have people negotiating on their behalf as well.

Mr. FIRMAN. So let me ask you a question here: if you are eligible for the transitional assistance, the card is free, and you are going

to get $600, so that is kind of a no-brainer. If you are not eligible for the transitional assistance, you may have to pay $10, $15, up to $30 a year. Are there very many people who will not save at least the price of a card somewhere or——

Mr. HELMS. Well, hypothetically, if someone paid $30 and never had a prescription filled, they would be out $30.

Mr. FIRMAN. Does anybody know what percentage of beneficiaries do not take any drugs?

Ms. STEPHENS. Very few.

Mr. FIRMAN. Very few; OK.

Ms. STEPHENS. Very few. Most of them do use a prescription. In 2002 about 91 percent of beneficiaries filled at least one prescription. Most Medicare beneficiaries do use a prescription drug. You do have beneficiaries who, as I think Bob is indicating, who may not have drug costs. I can tell you when we were working on the impact analysis, you assume that the people who are going to sign up kind of do the math a little bit and that beneficiaries who are going to sign up have somewhat higher drug costs so that they get a return for making the investment.

Mr. HELMS. Almost—I do not know the dispersion, but there are free cards. You do not have to pay $30.

Ms. STEPHENS. Yes, there are some cards with zero enrollment fee.

Ms. JAMES. In our study, we show what the fees are, and there are five national cards and seven regional cards that have no fee, and there is actually one card, one sponsor that has two cards, and one of them has a little higher fee, but you get a better price, and the other one is for people who do not use very many drugs, and so, the fee is lower, but the drug price is, like, 10 percent higher, which I thought was an interesting wrinkle.

Ms. STEPHENS. Actually, if I can make a plug for the Website again, people have been terrific about giving us ideas to make the Website better including the folks who have been doing studies and, working with it. We really, appreciate all of the input that folks have been giving us. But again, one of the new enhancements for the Website is now, as it is calculating, it is factoring in the enrollment fee into the savings that are being calculated. So it is trying to help beneficiaries with that judgment.

So that is another thing that has happened with the Website. It is now factoring in the enrollment fee.

Mr. FIRMAN. Good; thank you.

I have a question that something you said earlier, because the CMS Website is very good, and it is really designed, as I understand, to help you get the very best card, figure out what the best card is for the best savings. But, Bob, you said something earlier. You said—and maybe I heard you wrong, you said get a card; do not worry about getting the very best card. Get a card. What did you mean by that? I want to know——

Mr. HELMS. I mean, Julie disagrees from their findings, but I think what we were saying is that most of them are clustered toward the bottom. I mean, you can shop around and look at all of them, but most of them are going to be within 10 percent of the lowest price.

Mr. FIRMAN. So you are saying on the retail price side, there——

Mr. HELMS. No, I am talking about on the Medicare prices available with each card. There is not much difference from picking one card versus another.

Mr. FIRMAN. Would people agree with that, disagree with that?

Mr. HELMS. Julie found some exceptions.

Ms. GREALY. I think Julie found——

Ms. JAMES. Yes, we found that that was not true, that, in fact, actually—I would say, however, that if you are eligible for transitional assistance——

Mr. FIRMAN. We will get to that in a second.

Ms. JAMES [continuing]. That would hold. But if you are not, then, we did find just for a hypothetical individual buying four drugs that they could find—one of us found they would pay twice as much if they chose the highest card over the lowest. Now, that does not mean that some of the cards are not somewhere close together around the middle, but between the highest and the lowest, there was a significant——

Mr. FIRMAN. Did you do them about the same time? Was your study earlier, maybe, do you think?

Ms. JAMES. I think it was about the same time.

Mr. FIRMAN. About the same time, OK.

Mr. HELMS. We did ours around the first of June.

Ms. JAMES. No, the data were for June.

Mr. FIRMAN. So it is the same time period.

Ms. JAMES. I think it was the same. I think it is just this whole idea of highest and lowest.

Mr. HELMS. We think they are clustered toward the bottom end.

Mr. FIRMAN. Now, let me push you on one thing, because I agree with you up to a point, but I disagree with your point. I want to see where the other—and this is where you were beginning to go, Julie. That is true; it may not matter, you are going to get the same retail prices for most of the—many of the cards, but it probably does matter in picking cards in terms of the wraparound, because the wraparound coverage is—no card has all the wraparounds or different combinations of wraparounds, and our experience, and this is one of the drivers of the Accesstobenefits.org Website, is it agrees with you to the extent that retail price part does not matter, but you want to get the card with the most possible wraparounds, because those wraparounds are going to save you 80, 90 percent off the cost of the drug.

So I assume you meant other than the wraparound issue.

Mr. HELMS. Right, people not getting the $600.

Ms. GREALY. But I think we also thought it was important, and especially with the transitional assistance, you are going to save money regardless and that you do have the opportunity to change cards, you know, in November. So I think there was a big push, do not delay too long trying to find the absolute best card, but you can get some savings right away.

Mr. FIRMAN. Certainly do not delay, particularly if you are eligible for the transitional assistance, do not delay——

Ms. GREALY. A day.

Mr. FIRMAN. Well, too long, because you lose the $600 credit if you do not sign up by then.

Julie, I think it was you or somebody raised it, the issue of whether prices were stable or not, whether if I went on and looked at a card, and it said my price for Zocor was going to be $192, how likely is it—are the prices varying a lot, or is it pretty much the prices I get, I can count on will be the price when I have to go to the drug store a month or two later?

Ms. JAMES. We found some variation but generally very stable, and we have actually checked them just recently as well. Again, there are some little blips, but mostly pretty stable.

Mr. HELMS. Again, the ones we checked seemed to be going down a little bit.

Ms. JAMES. We did not find that.

Mr. FIRMAN. You did not find the same thing?

Ms. STEPHENS. Yes, I think the prices have been very stable. I think you have also seen some decreases, and I think you have seen a few increases. I think the Lewin study which has a table that indicates very stable prices and then some increases and quite a number of decreases. So I think some of the phenomena that you see where I say first time I looked, we were running 11 to 18 percent lower that national average retail prices; now, it appears to be 12 to 21.

Mr. FIRMAN. I had a question, but one—I am sorry, Mary, go ahead.

Ms. GREALY. No, I was going to say, "I think some of the charges that we were hearing early on, one, that prices would go up after people had gotten into the program or there would be the so-called bait and switch, it just has not played out." So as you said, "We just found a lot of stability in the program."

Mr. FIRMAN. Just to ask in fairness, though, I understand most of you did your studies on kind of average. You did not use very high expensive drugs? Or did you? The reason I ask there was a study for the Center for Medicare Advocacy and the Multiple Sclerosis Society which talked about a medicine that I think was costing, like, $2,000 or $3,000 a month which was not in a lot of programs, and that was going up and down. So I just want to first of all ask——

Ms. JAMES. We did look at some very high-cost——

Mr. FIRMAN. You did. That is great.

Ms. JAMES [continuing]. Biotech products and found that many of the cards did not cover them. They were not in our sample basket of 10, but we just looked and checked on some, and we did find out that there could be reasons for that. It could require specialty pharmacy or whatever. But we did find that a lot of cards did not have some of the very high-tech drugs.

Ms. GREALY. We looked at the 150 most often used drugs by seniors. We just thought that would be the most representative.

Mr. FIRMAN. Sharman, your study, too?

Ms. STEPHENS. We were dealing with.

Mr. FIRMAN. The average basket.

Ms. STEPHENS. The common.

Mr. FIRMAN. I think it is just important as we are putting this out for consumers to understand that if they are in a——

Mr. HELMS. We did the same.

Mr. FIRMAN [continuing]. OK, in those situations.

OK; well, how about—any of you have any questions of each other?

Ms. STEPHENS. I do want to ask Julie one question: you mentioned, and maybe I did not hear you correctly, that you thought one card was transitional assistance only?

Ms. JAMES. You know, it was the same sponsor, but it was, like, card A versus card B, and when I checked them out and called them, they told me that if you were transitional assistance, you got put in card A, and if you were not, you got put in card B. Otherwise, they were exactly the same.

Ms. STEPHENS. I wanted to talk a little more, because basically, the cards are, you know, that they are to service the entire Medicare population. We do see where some card sponsors do choose to have different pricing for the lower income population, where they are giving slightly better pricing, but it is the same card. So I want to get a little bit more information on that one.

Ms. JAMES. Yes, I kind of wondered about it, too.

Ms. STEPHENS. No, it is not like different cards for the transitional population. There may be different pricing within a card but not a different card.

Mr. HELMS. I have a question for Sharman, just curious.

Mr. FIRMAN. Fire away.

Mr. HELMS. You announced today that you are going to be sending out the cards to the low-income people, and Mark, if I heard him right, said that you are basing this off some eligibility list or some sort. You must have the addresses of people who are eligible for State Medicaid programs. How is it decided which card they get?

Ms. STEPHENS. OK; let me talk about what we are calling facilitated enrollment, which we announced today. We know about the Medicare population that is in what we call the Medicare Savings Programs, which is related to Medicaid, but these are people who do not have the full Medicaid benefit.

Mr. HELMS. 1.4 million?

Ms. STEPHENS. It is about 1.8 million.

Mr. HELMS. OK.

Ms. STEPHENS. So nearly 2 million people. These are Medicare beneficiaries who do not have full Medicaid benefits, so they do not have prescription drugs, but in fact, the State is helping to pay Medicare premiums and, in some cases, Medicare cost sharing.

What we are doing is using the information that we have to arrange for these beneficiaries to be enrolled. These are going to be national card sponsors with which we have worked and we will be—randomly assigning beneficiaries to the card sponsors who have volunteered to help with this effort.

Information will go out to these beneficiaries, including an enrollment package. As Dr. McClellan indicated, to activate the $600, all they need to do is either call the sponsor or call us and answer a couple of questions, and that will activate the $600.

Mr. HELMS. So when you mail them out, they actually get a card.

Ms. STEPHENS. Yes, what we are hoping, to do is to reach the beneficiaries thus far have not enrolled. These are beneficiaries who we think are eligible for the annual $600 in assistance, and we are very anxious to get to them so we can get to them the $600

that they have this year, and then, there is another $600 next year. Despite concerns over whether they get the best card our view on this one is right now, these people have not availed themselves. At a minimum, there is $1,200 on the table to help them and that what we are hoping is then, when they contact us they will be able to work with us.

They have the option to change the card but we are trying to reach these people and get the word out as much as we possibly can. We know from experience just with our mailers that when we send the mailers to folks, we do see an enrollment increase. My colleagues at the Website who are sitting here, see an increase to the calls at 1–800–Medicare.

So, we really want to reach these nearly 2 million people. I think the Access to Benefits Coalition has an objective, and it really is going to take grassroots efforts and as much outreach as we can possibly get, but the money is on the table. We need to come get them to come in. We hope this will work.

Mr. FIRMAN. I do want to say that this has been, we are delighted that the announcement has been made, because this is a group of people that especially if you look at the data base, QMBY-SLMBYs and QI1s, and you then sort out the ones who have already enrolled. This is people who you know are already eligible for the benefit, and we think this is a very efficient strategy, and we are going to do all we can to help encourage these people, because as Sharman said, this is a no brainer: take the $1,200. It may or may not be the card with the best wraparounds, but they can figure that out later. Get the $1,200.

But that leads me to another——

Ms. STEPHENS. Just so people know, we have had 19 cards raise their hand; it is 17 sponsors, but 19 cards are going to be participating in this.

Mr. FIRMAN. So they will each get just under 100,000, if we did the math right. Are those all national cards? Are some of them local?

Ms. STEPHENS. This time around, they are all national cards, just because of the complexity of doing the algorithms to do the random assignment. In order to get this done and to get it done so that we are in this window of this year, that is what it took.

Mr. FIRMAN. By the way, if people have questions, they should give them to one of the staff people; write them down and pass them up, and we will be happy to take any questions and answer them.

The question I have is I think we all agree that it is a no brainer for a person who is eligible for transitional assistance to sign up for the benefit. Does everyone agree with that? I assume that is a given. You get $1,200 in savings. You may get wraparounds. The savings, you said, are between 40 and 80 percent for people. Yet, we know there are 7 million seniors who are estimated eligible for the transitional assistance; about 1.3 million had signed up before the auto enrollment effort, which means that about 5.7 million so far on their own have not signed up.

Why? What is anybody's sense of why?

Ms. GREALY. I think there are two reasons. One, there was a tremendous amount of misinformation out there. This was a very

heated political debate, and again, I think a lot of misinformation. That is why we think it is important that we move past that. But I think more importantly, this often is a population that is just plain hard to reach, and I compare your effort, Jim, and our effort as I call it door-to-door sales. We are literally having to go person by person to work with these folks and to enroll them. They may not have access to the Internet; they may not have access to a telephone.

So it really is going to take a tremendous effort to do this outreach, and that is why I think this facilitated enrollment is such a great idea.

Ms. JAMES. Could I ask, Sharman, on that, what about people who are in nursing homes? Would not some of them be those people who have to have special packaging, et cetera, and the cards may not address their needs or be able to?

Ms. STEPHENS. Well, one of the things, and people may not be aware of this, there are actually cards that were developed card sponsors to work with the nursing home population. The pharmacies are working with the nursing homes. So, there are actually specialized cards for long-term care facilities.

Specifically, we have card sponsors, and we are working with the nursing home industry, and part of this is to get the $600, because there is a group of people who have not spent down to Medicaid who could use this to help pay for drugs.

Ms. JAMES. There are also, though, individuals who are in assisted living who need to have—what do they call it—special packaging, and I know that not all of the card programs can accommodate that kind of a need. So would the long-term care cards be the ones for——

Ms. STEPHENS. Yes, they are who we are working with—now, they are working with the nursing homes.

Ms. JAMES. I am just wondering if there is a gap here, if there is a group of individuals—I happen to have a family member, you can tell—who fall in this category where literally, I know that the pharmacies have told me no, I am sorry, we do not do that. But it is not a nursing home, so I am not sure the nursing home card works. So you might just think about that.

Ms. STEPHENS. No, that is a good point. I need to check, Julie.

Mr. FIRMAN. So I guess the question is are you doing auto-enrollment for the nursing home QMBY–SLMBYs, too? Or we do not know?

Ms. STEPHENS. Is Lynn still here?

Mr. FIRMAN. I was hoping to ask a question that somebody did not know the answer to, but there are so many experts in the room that I can tell I will never be able to do that. That is great. Thank you for that answer.

Mr. HELMS. Could I take a stab at your question?

Actually, I have to ask another question. Whoever came up with the 7.5 million that potentially might be eligible for this? The researcher in me says you have to look at the distribution of the people's demand for drugs. In other words, what is the utilization among that population? You are going to have a minority of those people who are the big drug users, and they are going to have a greater incentive to come sign up.

But you are probably going to have a majority of them who do not consume a lot of drugs. I mean, if they do, it would be a big advantage, but until that time, they do not have any strong incentive to pay attention to the ads or do anything about it.

Ms. STEPHENS. Maybe what I can do is help, since one of the things I got to do was work on the impact analysis, where I think some of these numbers are coming from.

Just as you said, Jim, we estimated in terms of eligible. If we just look at income, you know, and lack of drug coverage, for example, we estimated that 7.2 million beneficiaries were eligible for the transitional assistance program. Then, our actuaries, in looking at, I think, the phenomenon that Bob is talking about, which is people's drug spending and also experience in looking at what we call uptake, how many people will actually go to enroll, we estimated that we thought about 4.7 million people would actually enroll in the transitional assistance program.

We are currently at 1.1, so we have got some people we need to go find and get enrolled.

Mr. FIRMAN. I do want to note before you do that——

Ms. STEPHENS. But based on our actuaries' estimates——

Mr. FIRMAN. Before you do that, we at the Access to Benefits Coalition looked at that 4.7 estimate, and we said that is not good enough. We want to do better. We set an objective of 5.5. So we are working together. We have both got a long way to go, but I wanted—if it is 4.7 or 5.5, it underscores the importance of the automated, facilitate enrollment initiative, because we will not get all 1.8 million, but if we get most of those people, that is going to go a long way to achieving our shared objectives here.

Ms. GREALY. But, Jim, I think if you were to take a look at other Federal programs or even look at the QMBY-SLMBY and the rates of enrollment of people who are qualified and yet not enrolling; you look at the SCHIP program. So I commend you on setting that goal, but I think if you even look at the experience in other Federal programs that offer tremendous help for low-income beneficiaries, sometimes, they are not enrolling.

So that is why I think this facilitated enrollment is a whole new approach, and it will be great to see how it works.

Ms. STEPHENS. No, I think that is right. I want to clarify one thing: the letter that is going to be going out to the QMBY/SLMBY population is going to say that if you are in a long-term care facility or the other special card that we have that relates to the American Indian population, who may be using pharmacies that are on the reservations, that we say please call us at 1–800–Medicare, and we are going to help get you to the right card that is working with the appropriate pharmacies.

But I still want to follow up on assisted living, because more and more beneficiaries are living in assisted living.

Mr. FIRMAN. You know, Mary's point about if you looked at enrollment in other Federal programs, they do not always do that well, do you have any more specific data, Sharman, on how is the enrollment experience or targets compare to the takeup on other Federal benefits?

Ms. STEPHENS. Well, the most recent experience is really with the State Children's Health Insurance Program, the SCHIP pro-

gram. One year into the program, they were at about 55 percent of what the estimated enrollment was.

Ms. GREALY. That was not 50 percent of those eligible.

Ms. STEPHENS. Yes.

Ms. GREALY. That was just their target——

Ms. STEPHENS. Yes.

Ms. GREALY [continuing]. For that first year.

Ms. STEPHENS. We now are at about 60 in 3.5 months, for this discount card program.

Mr. FIRMAN. By the way, I do not know if there are any questions, but I have not gotten them if they are coming up to the front.

Ms. STEPHENS. I think the experience we are gaining now with the discount card our partners, the local communities, and the organizations that work with this population is actually pretty important, because we have a bigger challenge facing us, which is the drug benefit itself.

There, we are talking about, just a huge population to educate and outreach to, and so, I think we can learn a lot from this experience and be in a better position.

Mr. FIRMAN. We could not agree with you more. That is why the Access to Benefits Coalition was formed, to get the people into the low-income Part D subsidies. In fact, we are going to be doing a major benchmarking study of the best outreach activities that go on between now and the end of the year, and then, early next year, we are going to zero in and look at them.

But I also want to go back to this question of Mary's point of that yes, it is true that after all these years, maybe half the people eligible for Medicaid, Food Stamps, or SSI do not take them, and even though we know, we think they should, because it is really good money, and they ought to do it, so that says to us that—to Sharman's point that we have to do things differently. We do the same things over and over again, we are going to get the same result, which is also the definition of insanity.

One of the things that we have come to the conclusion and why we are so excited about the automated enrollment, if you look at the history of public benefits outreach and say what has happened, whether it is Medicaid, Food Stamps, the Pfizer Share Card, the patient assistance program, the EPIC State program, they have all approached things the same way: they have said our challenge is to find the needles in the haystack. We need to go out and find among all these people the few people that are eligible.

So, literally, everybody repeats the same process over and over again. We have concluded looking at this that this is exactly the wrong way to approach things, and that is why we get such abysmal results. The strategy is not look for the needles in the haystack; it is look for the piles of needles. Somebody has already found almost everybody that we are looking for. CMS, you have found 1.8 million of them in one pile called this program. The Pfizer Share Card has another pile. Together RX has another pile. Every State pharmacy program is another pile. Every home energy assistance program is another pile of low income people.

What we need to start to realize is instead of spending the same money and finding these people again and again and again and again, say who has already found them, and how can we figure

out—and then, we can focus our efforts on marketing and convincing them, because one of the things we found, we had a project we are doing in the State of Pennsylvania where they have this list of people who they know are eligible for a $500 property tax, just a check in the mail, and they call them up, and they are also eligible for QMBY-SLMBY, you know, $800 a year in savings, and we call these people up, and we say great news, you are eligible for $500 and $1,200 in savings, and they say, "Oh, no, thank you. I do not want to do that." There are some attitudinal barriers or other kinds.

So we go back to them and say let me explain this to you. You know, this is $800 a year for 10 years. This is $8,000. They say, "Well, I am not sure," and they said, "Well, do you have grandchildren? Yes. Well, would you not rather have $8,000 and give it to your grandkids?" It sometimes takes a lot of effort. The point is it is worth it if you know that a person is eligible to go back to them again and again and again.

So one of the learnings that we are urging everybody to do is find the piles of needles that you already have and focus on those efforts. We actually believe that is going to be one of the strategies that can make a difference in this effort going forward.

Are there any more questions from the audience?

Any questions from the panelists?

If not, I really want to thank everybody for coming here today for all of the work you have done in these studies. It is reassuring to see that people are approaching things differently and reaching the same conclusions, and those conclusions, to me, are pretty clear. If you are 1 of the 7 million people eligible for the transitional assistance, it is an absolutely no-brainer that you should take these benefits, and you are going to save 40 to 70 or 80 percent on your medications.

If you are not eligible for the transitional assistance, and you have drug costs that are significant at all, at least $500 or $1,000 or more, chances are, which is the case for most elderly people, you are going to be able to find discount cards through Medicare.gov or elsewhere that are going to save you significant 10, 20, at least, percent, which would more than justify a fee, maybe, of $30.

So this is great. I hope we will have another one of these in a year from now, and we can have more data on what has been saved, and I thank the audience for participating and the Senator for bringing us together in the first place and the Committee.

Thank you very much, and this forum is adjourned. [Applause.]

[Whereupon, at 4:28 p.m, the forum concluded.]

APPENDIX

Assessment of Beneficiary Savings in the Medicare Drug Discount Card Program

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August 12, 2004

Table of Contents

I. EXECUTIVE SUMMARY 1

II. BENEFICIARY SAVINGS 3

A. Best Available Discounts for 150 Most Commonly Prescribed Drugs 4
B. Variation in Average Discount levels for Different Discount Cards 5
C. Savings for Beneficiaries with Specific Chronic Diseases 6
D. Savings for Low-Income Beneficiaries 7

III. REGIONAL VARIATION 12

A. Variation in Prices Across Geographic Markets 12
B. Savings in Urban and Rural Areas 13
C. Variation in Prices at Different Pharmacies 15

IV. AGGREGATE SAVINGS 17

A. Estimate of National Savings 17
B. Estimates of State-Level Savings 21

V. CONCLUSIONS 24

APPENDIX A: TABLES

List of Figures

Figure 1a. Distribution of Brand Drugs by Discount Level 4
Figure 1b. Distribution of Generic Drugs by Discount Level 5
Figure 2. Savings for Each Discount Card Sponsor Offering Top 25 Drugs Nationally 6
Figure 3. Annual Costs for Beneficiaries with Various Chronic Conditions, with and without Card Discounts and the $600 Federal Credit for Low-Income Beneficiaries 7
Figure 4. Savings for Various Treatment Regimens of Common Chronic Diseases 8
Figure 5a. Additional Savings from Manufacturer Assistance Programs: Diabetes and Hyperlipidemia 9
Figure 5b. Additional Savings from Manufacturer Assistance Programs: Multiple Chronic Conditions 9
Figure 5c. Additional Savings from Manufacturer Assistance Programs: Diabetes, Hypertension and Hyperlipidemia 10
Figure 6. Best Available Price for a Top-Selling Hypertension Drug in 20 Markets 11
Figure 7. Savings in Selected States Based on Best Available Price for 150 Drugs 12
Figure 8a. Urban vs. Rural Pricing for a Generic Drug 13
Figure 8b. Urban vs. Rural Pricing for a Brand Name Drug 13
Figure 8c. Urban vs. Rural Pricing for a Diabetes Drug Regimen 14
Figure 9. Variation in Price for a Single Drug at Multiple Pharmacies 15
Figure 10. Participating Beneficiaries by Eligibility Group 16
Figure 11. Per Capita Savings by Income Group 17
Figure 12. National Per Capita Beneficiary Savings over 18 Months 18
Figure 13. Aggregate Savings from Discounts and $600 Federal Credit (in millions) 19
Figure 14. National Aggregate Savings with Program 19
Figure 15. Aggregate National Beneficiary Savings over 18 Months for Selected Sub-Populations 20
Figure 16. Per Capita Savings by State for All Participating Beneficiaries 21
Figure 17. Aggregate Savings by State for All Participating Beneficiaries (in millions of dollars) 22

I. EXECUTIVE SUMMARY

This paper examines savings available to Medicare beneficiaries who elect to participate in the Medicare-endorsed discount card program. We present estimated average savings for beneficiaries who shop at retail pharmacies using the discount card, including the value of the annual $600 federal credit available to qualifying low-income beneficiaries. We also estimate aggregate savings based on the number of beneficiaries CMS projects will use the discount cards.

Lewin's estimates of individual beneficiary savings reflect the difference in price between what a cash purchaser would pay with and without one of the new Medicare drug discount cards. We compared Medicare discount card prices posted on the CMS website to average retail prices in each state for the 150 drugs most commonly prescribed to seniors. We also compared prices for a market basket of the 25 drugs prescribed most frequently to Medicare beneficiaries, and for typical drug regimens used to treat common chronic diseases among Medicare beneficiaries. All comparisons are based on a 30-day supply of the most common form and strength of each drug. We limited our examination to discounts available to retail purchasers who continue to shop at retail pharmacies; we did not assess the possibly greater discounts available to purchasers who switch to mail-order pharmacy service.

The estimates shown here reflect a snapshot of the savings available in the early months of the drug discount program. Initial price data was collected from the Medicare website during the first and second weeks of June 2004 as beneficiaries were starting to enroll; additional price data was subsequently collected during the last week of July. Prices collected during both time periods are presented in this study, though we found that because the majority of prices did not change from June to July, our estimates of overall savings were essentially the same using June and July data.

The focus of this study is on savings available to beneficiaries who currently lack drug coverage and pay retail price for their drugs, as these beneficiaries have the highest out-of-pocket prescription drug expenditures and stand to gain the most from the discount card program. Many Medicare beneficiaries already use drug discount cards from insurers, drug manufacturers, or other sources, and this study does not attempt to assess how many of these existing cards have been issued or to quantify the extent to which various beneficiaries are already achieving some savings from them. For those beneficiaries already using a discount card of some sort, the net new savings from the Medicare program will be lower than shown here. Similarly, many beneficiaries are enrolled in and receive substantial savings from state pharmacy assistance programs, and state approaches to coordinating with the discount card program and the $600 federal credit vary. Assessing the impact of the Medicare drug discount card program on beneficiaries on these state programs[1] was beyond the scope of this study.

[1] At the same time, this study calculates aggregate savings using CMS enrollment projections, which do reflect some states' decisions to automatically enroll state pharmacy assistance program participants into the discount card program.

Key findings from the study include:

- Nationally, the best discount cards offer savings of almost $10 per prescription, representing a discount of more than 20 percent overall. More than half of the cards deliver savings of more than $8.48 per prescription, or 17.2 percent. The best card yields potential savings of more than $850 over 18 months for a typical Medicare beneficiary without drug coverage.

- Overall, beneficiaries participating in the program over 18 months would save an average of $1,247 per capita, compared to median current retail spending of $3,514. Beneficiaries with incomes below 135 percent of poverty using the discount card plus the $600 federal credit will save an average of $1,548 over 18 months.

- Across the top 150 drugs, the best available price from any card sponsor represents an average savings per prescription of $17.37, or 23 percent. Of this total, brand name drugs contribute $12.68 (18.6 percent), while generic drugs contribute $4.68 (67.5 percent).

- Beneficiaries on a typical hypertension regimen can save an estimated $254 annually, while beneficiaries using a common diabetes regimen could save $480 annually.

- By combining discounts, transitional assistance and pharmaceutical manufacturer assistance programs, low-income beneficiaries can achieve substantial savings. For example, a beneficiary taking a typical combination of drugs for diabetes and hyperlipidemia would spend $3,337 paying retail prices. Using the discount card that provides the best available prices on those drugs, the beneficiary would save $878, or 26 percent. Combining these discounts with the $600 federal credit and manufacturer assistance, however, a beneficiary could save up to $2,198, or 66 percent.

- The best available price for a medication is generally offered consistently across all markets, and there is very little variation in discounted prices between rural and urban areas. However, the amount a beneficiary may save varies because of the variation in the retail prices they pay today.

- In aggregate, beneficiaries could save up to $7.7 billon, assuming that CMS enrollment projections are achieved by the end of this year.

In Section II, we discuss the estimated average discounts from the discount cards to answer the question: how much can beneficiaries save overall, and how much for specific drugs? We also address savings for beneficiaries being treated for specific chronic diseases and for low-income beneficiaries. In Section III, we discuss the degree to which discounted prices vary by state, for urban versus rural areas, and by type of pharmacy. Estimates of aggregate savings are presented in Section IV.

II. BENEFICIARY SAVINGS

In this section we discuss national average savings for the typical Medicare beneficiary, as well as for subgroups of Medicare beneficiaries, such as diabetics, hypertensives and low-income beneficiaries. We used several approaches to estimate savings for individual Medicare beneficiaries, including (1) identifying the lowest price available across all cards for commonly used drugs, (2) evaluating average savings on a card-by-card basis for the 25 most frequently used drugs, and (3) calculating savings for beneficiaries with specific chronic diseases based on typical drug regimens.

These three approaches each offer useful insight into the value of the discount cards to different Medicare beneficiaries. Beneficiaries who use one or two drugs will likely select a card based on the best available price for those drugs. For these beneficiaries, the analysis of available discounts by drug can be used to estimate their expected savings. However, many Medicare beneficiaries taking multiple drugs cannot take advantage of the best available discount for each drug they take, as they may only sign up for one card. To estimate average savings a beneficiary could expect to achieve, we compared average discount levels across cards for the 25 most frequently prescribed drugs. The third analytic approach focuses on savings for beneficiaries with specific chronic diseases. In this analysis, we provide illustrative examples of the savings available to a beneficiary taking typical drug regimens for common chronic diseases.

Savings were calculated by comparing Medicare discount card prices posted on the CMS website to average retail prices for the 150 drugs most commonly prescribed to seniors[2]. The retail prices used as a comparison reflect a 12-month average drawn from a national database of millions of prescription drug claims and represent a conservative estimate of what a cash-paying customer would pay[3]. Prices were compared for the most common form and strength for each drug on a state-by-state basis, so that appropriate comparisons could be made across geographic areas. Unless otherwise noted, estimates reflect savings off the national average retail price.[4]

Lewin collected price data from the Medicare website during the weeks of May 24 and June 1, and then again during the week of July 26. We were able to compare the best available prices for the top 150 most commonly prescribed drugs, as well as the savings achieved by discount cards for the market basket composed of the top 25 drugs, at those two points in time. These comparisons are shown in **Table 1** and **Table 2**, respectively, in the Appendix.

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[2] Lewin included only drugs in pill or tablet form because other forms were subject to reporting errors in the initial weeks of the program's website.

[3] Data used to establish benchmark prices is from Verispan, and reflects usual and customary prices for patients over age 65, including those with third party coverage and Medicaid, adjusted to reflect prices paid by cash customers. Lewin analysis indicates that benchmark prices used here are substantially lower than retail prices observed in proprietary data sources or collected and reported publicly (such as on the Maryland Attorney General website).

[4] National savings estimates are calculated by comparing discounted prices from the CMS website collected in several zip codes in Chicago and New York to national average benchmark prices; it is possible to extrapolate from these specific zip codes given the uniformity in card sponsor prices across geographic areas (see Section III of this study).

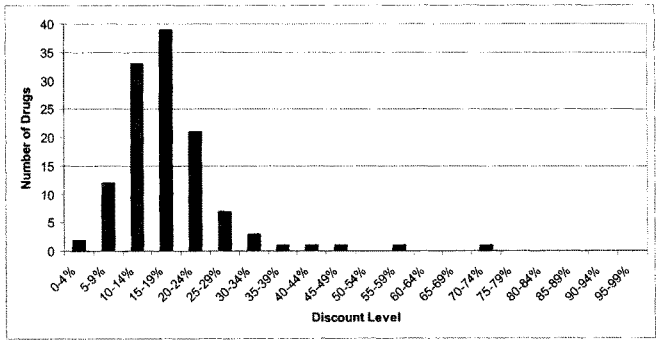
We found that there has been little change in the best available prices; data collected in July suggest weighted average savings of $17.37 per prescription, or 23 percent, compared with savings of $16.57, or 22 percent, per prescription in June. The analysis of discount variation for a market basket of 25 drugs shows that by July 26, there were more discount cards covering a broader range of drugs, but the discounts available to beneficiaries were not notably different. In all, though there were some price changes for individual drugs, overall savings were not affected.

A. Best Available Discounts for 150 Most Commonly Prescribed Drugs

Lewin collected the lowest prices available from any Medicare discount card for each of the 150 drugs most commonly prescribed to seniors (see **Table 1** in the Appendix)[5]. Overall, the best available prices represent average savings of $17.37 per prescription, or 23 percent.[6]

Brand name drugs account for the majority of the dollar savings, with average savings per prescription of $12.98, or 18.6 percent. Because generic drugs are less expensive initially, dollar savings for generic prescriptions are lower, averaging $4.68, while average percentage savings are higher at 67.5 percent. The size of the discounts for brand and generic drugs varies widely across discount cards, as shown in **Figures 1a and 1b** below.

Figure 1a. Distribution of Brand Drugs by Discount Level

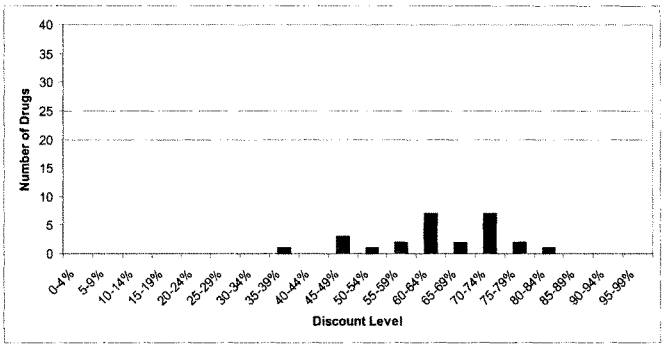


Source: Medicare.gov, week of July 26, 2004.
Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

[5] Lewin collected data on the top 150 drugs during the week of June 1, 2004. Data was recollected the week of July 26, 2004 because card sponsors were still developing their programs at the time of initial collection. Two drugs are not included in the later data because they are now listed as drugs excluded from the Medicare-approved drug discount card program; pricing is not available.

[6] Savings estimates for specific drugs were weighted to reflect total retail sales volume, in order to give more emphasis to the drugs most frequently used, and lower emphasis to drugs which are used less often.

Figure 1b. Distribution of Generic Drugs by Discount Level



Source: Medicare.gov, week of July 26, 2004.
Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

B. Variation in Average Discount levels for Different Discount Cards

A key objective of this study was to assess how the cards perform on average for beneficiaries with a wide variety of medical conditions. To evaluate whether some card sponsors consistently provide higher savings than others, Lewin created a market basket of the 25 drugs most commonly prescribed to seniors. We then compared the prices for each discount card, as if a beneficiary purchased all drugs using the discount card at a single pharmacy. In order to give greater weight to the drugs that seniors use most often, savings for each drug were weighted to reflect total retail sales volume among the over-65 population.[7]

We find that available discounts vary widely by card sponsor, and that the discount card a beneficiary chooses has significant effect on his or her overall level of savings. In **Figure 2** we plot the weighted average savings for each of the 34 discount cards that offered at least 20 of the 25 drugs in the market basket. Out of the 43 cards available in the market tested, 24 discount cards offer discounted prices for all drugs included in Lewin's market basket. In order to compare savings across a broader group of discount cards, we included ten additional discount cards offering discounts on at least 20 of the 25 drugs. CMS regulations stipulate that if the discount card a beneficiary chooses does not offer a discount for a given drug, or if the discount price at the pharmacy is higher than that which the pharmacy would otherwise charge a cash-paying customer, a beneficiary will pay the pharmacy's usual and customary price. To be consistent with the regulations, when comparing savings for these discount cards we assumed that the beneficiary would pay the average retail price.

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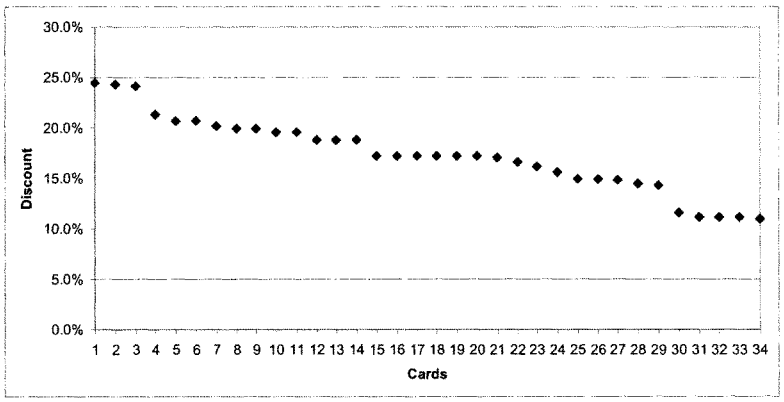
7 Unweighted savings estimates would be higher because of certain very high discounts on less frequently prescribed drugs. The weighted average more accurately reflects dollars saved by beneficiaries by putting more emphasis on drugs prescribed more frequently.

The distribution in **Figure 2** shows that the "best" discount card offers average savings of 24.4 percent, or $12.04 per prescription. All of the cards in the top quartile provide savings of at least 19.9 percent, and the median card offers savings of 17.2 percent, or $8.48 per prescription. A beneficiary who chooses a good value card (among the top nine) can expect savings of at least $699 over 18 months. In contrast, a few cards at the other end of the distribution provide savings of less than $400, or 11.5 percent, over 18 months. **Table 2** in the Appendix of this document details the amount of dollar savings per prescription and per capita for each of the 34 cards represented in the figure below.

Figure 2. Savings for Each Discount Card Sponsor Offering Top 25 Drugs Nationally



Source: Medicare.gov, July 26, 2004.
Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

The aggregate savings estimates presented at the end of this study draw on these findings, and assume that beneficiaries will enroll in a card at the 75th percentile (with savings of 19.9 percent).

C. Savings for Beneficiaries with Specific Chronic Diseases

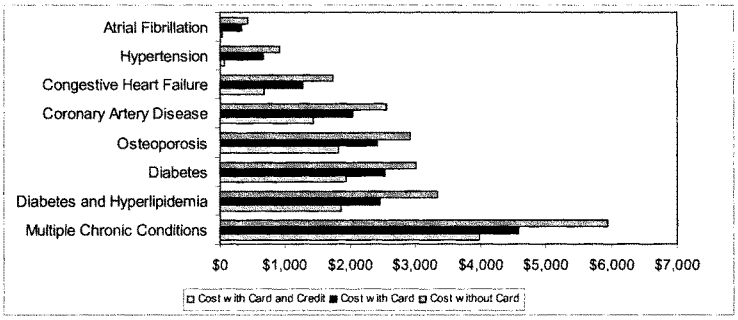
Lewin examined model drug regimens for multiple disease groups to assess level of savings[8].

Savings for each of the drug regimens were estimated by collecting drug prices using a single card at a single pharmacy. These results are shown in **Figure 3** for several regimens related to diabetes, hypertension and other chronic conditions. Savings for patients with diabetes range from 13 to 26 percent, translating to estimated annual savings of $346 to $878 nationwide.

[8] Regimens were developed by a Lewin physician.

Beneficiaries using a typical hypertension regimen would save an estimated $254 annually, or 28 percent.

Figure 3. Annual Costs for Beneficiaries with Various Chronic Conditions, with and without Card Discounts and the $600 Federal Credit for Low-Income Beneficiaries



Source: Medicare.gov, week of June 1, 2004.
Note: Data collected in zip code 11758 in New York. Savings calculated off National Retail Benchmark.

D. Savings for Low-Income Beneficiaries

The discount card program will have the largest impact for beneficiaries who are also eligible for the $600 federal credit accessible through the discount card. Beneficiaries with incomes below 135 percent of poverty are eligible to receive a $600 federal credit per year toward the purchase of prescription drugs, or $1,200 over the life of the discount program. **Figure 3** above shows annual costs for low-income beneficiaries with diabetes and other chronic conditions, including the effect of the $600 federal credit, while **Figure 4** provides additional detail on the drug regimens and their associated savings.

A number of drug manufacturers – Abbott, AstraZeneca, Johnson & Johnson, Eli Lilly, Merck, Novartis, and Pfizer – have partnered with various discount card sponsors to offer new low-income assistance programs that work in concert with Medicare drug discount cards. These manufacturer assistance programs offer free or low-cost prescriptions to low-income beneficiaries. Program eligibility requirements and benefits vary in several ways, including the out-of-pocket cost to the beneficiary and the selection of drugs available to the beneficiary.

In general, manufacturers offer drugs to low-income beneficiaries for $0 to $15 per prescription once they have exhausted the $600 federal credit. The seven manufacturers sponsoring assistance programs work with between 1 and 30 discount card sponsors each and there are 35 discount cards that participate with at least 1 manufacturer program. Program eligible beneficiaries who enroll in one of the 35 discount cards are automatically enrolled in any manufacturer assistance programs available through the discount card of their choice; each discount card sponsor is responsible for administering the program to its respective enrollees.

Manufacturers have included different numbers of drugs in their programs; in total, there are 210 drugs that are free or available for as little as $15 to eligible enrollees.

Figure 4. Savings for Various Treatment Regimens of Common Chronic Diseases

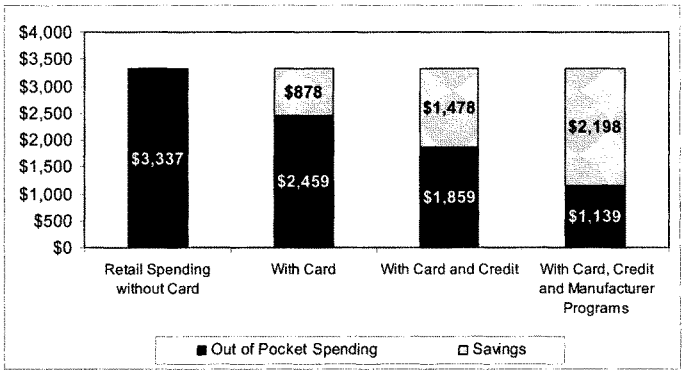
Drug Information				Annual	Annual Savings			
Drug	Used to Treat	Dosage	Brand or Generic	Retail Spending	With Card ($)	With Card (%)	With Card and Credit ($)	With Card and Credit (%)
Diabetes I				$ 3,014	$ 480	16%	$ 1,080	36%
Glyburide	Diabetes	2.5 mg	G					
Glucophage	Diabetes	500 mg	B					
Actos	Diabetes	30 mg	B					
Diabetes II				$ 2,121	$ 467	22%	$ 1,067	50%
Metformin	Diabetes	500 mg	G					
Glucotrol XL	Diabetes	10 mg	B					
Avandia	Diabetes	4 mg	B					
Diabetes and Hyperlipidemia I				$ 3,752	$ 901	24%	$ 1,351	36%
Glucophage	Diabetes	500 mg	B					
Actos	Diabetes	30 mg	B					
Pravachol	Hyperlipidemia	40 mg	B					
Diabetes and Hyperlipidemia II				$ 3,337	$ 878	26%	$ 1,478	44%
Glucotrol XL	Diabetes	10 mg	B					
Avandia	Diabetes	4 mg	B					
Zocor	Hyperlipidemia	20 mg	B					
Diabetes and Hypertension				$ 2,551	$ 346	14%	$ 946	37%
Altace	Hypertension	10 mg	B					
Avandia	Diabetes	4 mg	B					
Lipitor	Hyerlipidemia	10 mg	B					
Osteoporosis, Osteoarthritis, and Chronic Allergies				$ 2,914	$ 500	17%	$ 1,100	38%
Allegra	Allergies	180 mg	B					
Celebrex	Osteoarthritis	200 mg	B					
Evista	Osteoporosis	60 mg	B					
Hypertension				$ 921	$ 254	28%	$ 854	93%
Norvasc	Hypertension	5 mg	B					
Lisinopril	Hypertension	10 mg	G					
Hydrochlorothiazide	Diuretic	25 mg	G					
Congestive Heart Failure and Hypertension				$ 1,731	$ 454	26%	$ 1,054	61%
Enalapril	Hypertension	10 mg	G					
Coreg	Congestive Heart Failure	25 mg	B					
Lasix Oral	Congestive Heart Failure	40 mg	B					
Coronary Artery Disease				$ 2,562	$ 531	21%	$ 1,131	44%
Toprol XL	Coronary Artery Disease	50 mg	B					
Altace	Hypertension	10 mg	B					
Pravachol	Hyerlipidemia	40 mg	B					
Treatment for Individual with a History of Atrial Fibrillation				$ 427	$ 97	23%	$ 394	92%
Lanoxin	Antiarrhythmic	0.125 mg	B					
Coumadin Tabs	Anticoagulant	5 mg	B					
Multiple Chronic Conditions				$ 5,948	$ 1,363	23%	$ 1,963	33%
Vioxx	Osteoarthiritis	25 mg	B					
Fosamax	Osteoporosis	70 mg	B					
Nexium	Acid Reflux	40 mg	B					
Singulair	Allergies	10 mg	B					
Zoloft	Depression	50 mg	B					
Metoprolol Tartrate	Hypertension	50 mg	G					

Source: Medicare.gov, week of June 1, 2004. Note: Regimens developed by a Lewin physician.
Note: Data collected in zip code 11758 in New York. Savings calculated off National Retail Benchmark.

Given the variation in these programs and the fact that their overall impact depends heavily on which discount cards beneficiaries choose, it is not possible to estimate their aggregate effect at this time. As a result, the aggregate estimates in Section IV do not include the effect of these programs. The following three examples, however, indicate that the impact of manufacturer assistance programs would be quite large. For example, **Figure 5a** illustrates the savings for a typical combination of drugs used to treat diabetes and hyperlipidemia. Manufacturer programs would save the beneficiary an additional $720 on their annual drug costs; total

savings with the discount card, $600 federal credit and manufacturer programs would be nearly 66 percent.

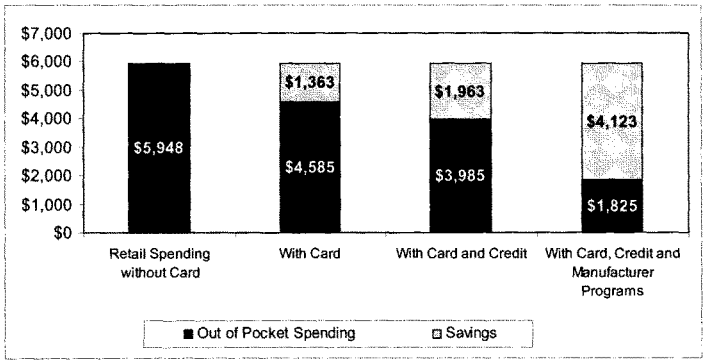
Figure 5a. Additional Savings from Manufacturer Assistance Programs: Diabetes and Hyperlipidemia



Note: The discount card illustrated in this example offers the best available price for the disease regimen, which includes Glucotrol XL, Avandia and Zocor. The card sponsor has an agreement with one of the manufacturers to provide the drug to eligible enrollees at no cost once the $600 federal credit is exhausted.

In **Figure 5b**, a beneficiary with multiple chronic conditions would save $2,160 more with the manufacturer assistance program than with the discount card and $600 federal credit alone. This amounts to an additional savings of about 36 percent off the retail price, for total savings of 69 percent.

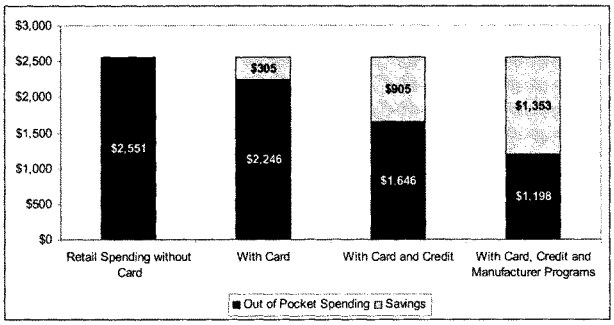
Figure 5b. Additional Savings from Manufacturer Assistance Programs: Multiple Chronic Conditions



Note: The discount card chosen offers the best available price for the disease regimen, consisting of Vioxx, Fosamax, Nexium, Singulair, Zoloft and Metoprolol Tartrate. The discount card sponsor has an agreement with the manufacturer of three of the drugs; the manufacturer provides those drugs free to eligible enrollees after the $600 federal credit is exhausted.

Notably, the savings from these programs are large enough to influence which card is best for a beneficiary. For example, a low-income beneficiary being treated for diabetes, hypertension and hyperlipidemia using the drug regimen shown above in **Figure 4** would save $946, or 37 percent annually by choosing the discount card with the best available prices for that regimen as shown on Medicare.gov. But if the beneficiary instead chooses a discount card that has partnered with a drug manufacturer to offer additional assistance, the beneficiary could save up to $1353, or 53%. This example underscores the importance for beneficiaries of evaluating not only the best available prices on the website but the specific arrangements that card sponsors have with manufacturers to offer additional savings on the drugs they are taking.

Figure 5c. Additional Savings from Manufacturer Assistance Programs: Diabetes, Hypertension and Hyperlipidemia



Note: The discount card chosen offers prices for the disease regimen, consisting of Altace, Avandia, and Lipitor. The discount card sponsor has an agreement with the manufacturer of one of the drugs; the manufacturer provides those drugs for $15 to eligible enrollees after the $600 federal credit is exhausted.

Certain manufacturers and discount card sponsors extend the assistance programs to beneficiaries with incomes between 135 and 200 percent of poverty. Upon enrollment, the beneficiaries pay the flat fee, between $0 and $15, for certain prescriptions. If the beneficiary shown in **Figure 5c** did not qualify for the $600 federal credit but had an income less than 200 percent of poverty, the beneficiary would then save $902, or 35 percent.

Lewin's estimates reflect savings from usual and customary prices without discounts, but it is important to note that many beneficiaries receive assistance today from state pharmacy assistance programs, existing manufacturer programs and other sources. Further research would be required to understand the effect of the discount card on these beneficiaries, though net new savings for beneficiaries in such programs will be lower than shown here.

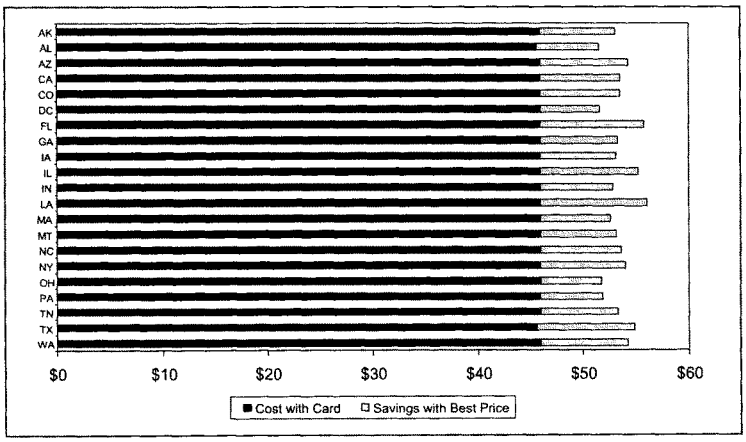
III. REGIONAL VARIATION

A. Variation in Prices Across Geographic Markets

Today, retail prices for prescription drugs vary by region, by state, between urban and rural areas, and by type of pharmacy. Benchmark price data compiled by Lewin indicates that on average, retail prices are slightly lower in rural states. When we compare current retail price levels across states, we find the lowest retail prices in Maine, with average prices 15 percent lower than in Florida, the state with the highest prices. More striking, however, is the degree of variation found across pharmacies within states. For example, a review of the usual and customary prices published by the Maryland Attorney General on their website indicates that the prices for the same drug frequently vary by as much as 50 percent from one pharmacy to the next.

To provide a preliminary assessment of the degree to which prices - and savings - vary geographically under the new Medicare drug discount program, Lewin collected price data from the CMS website for multiple urban markets. Notably, we found that the best available price offered for a single drug seldom varies across markets. For example, as depicted in **Figure 6**, the lowest available price for a best-selling brand-name hypertension drug varies by less than $1 across 20 zip codes (all in different states) and that in 18 of the 20 markets, the price was *exactly* the same. This result was confirmed many times with additional data collection efforts.

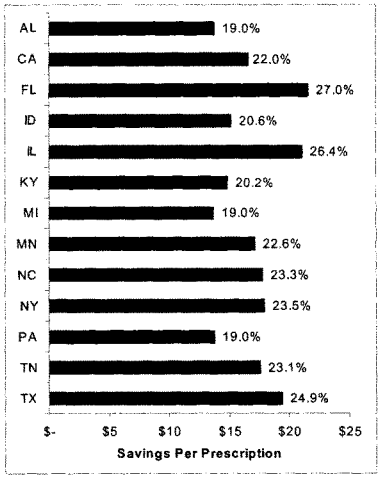
Figure 6. Best Available Price for a Top-Selling Hypertension Drug in 20 Markets



Source: Medicare.gov, April 30, 2004.

Table 3 in the Appendix provides additional detail on the benchmark and discounted prices. While discount card sponsors offer uniform pricing nationwide, the *savings* from the Medicare drug discount cards vary geographically due to the variation in today's retail prices. As shown in **Figure 7**, beneficiaries in states such as Florida, Illinois and Texas, where current retail prices are higher, will see the largest savings from the discount cards.

Figure 7. Savings in Selected States Based on Best Available Price for 150 Drugs

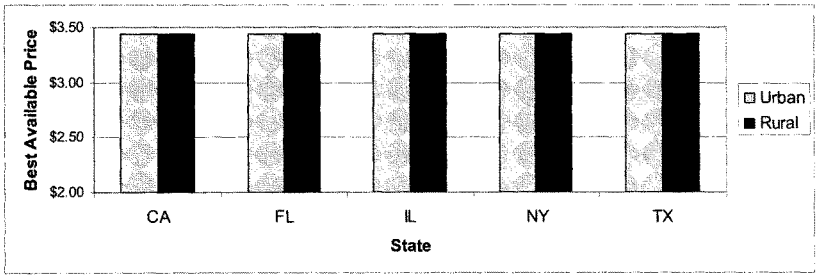


B. Savings in Urban and Rural Areas

In addition to evaluating savings levels across geographic areas, Lewin assessed whether Medicare beneficiaries living in urban and rural areas have comparable access to drug card discounts. While drug prices for a given card are consistent across geographic regions, there may be variable access to these prices across urban and rural markets if certain discount cards are not available in a given area or if pharmacies do not accept the discount cards.

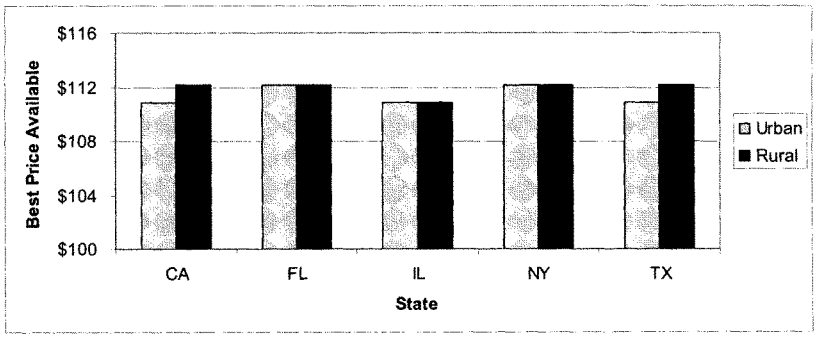
Lewin investigated whether there are differences in discount card availability and acceptance based on three commonly prescribed brand name drugs, three generic drugs, and three disease regimens. The best available price and the number of discount cards available were collected in a major urban market in each state, as well as in a rural area in the same state. As shown in **Figures 8a, 8b** and **8c,** we found little or no variation in price across these markets.

Figure 8a. Urban vs. Rural Pricing for a Generic Drug



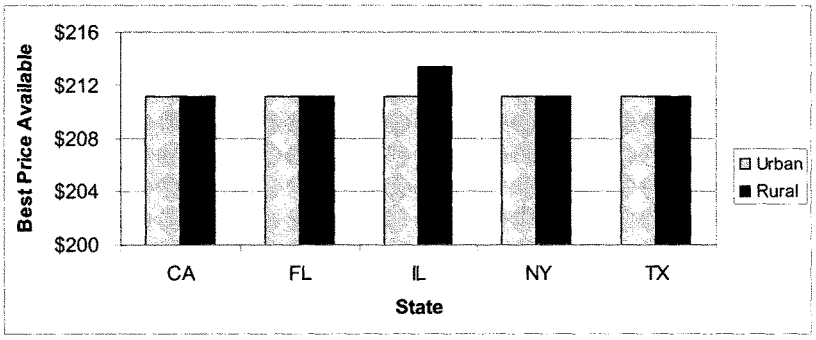
Source: Medicare.gov, May 17, 2004

Figure 8b. Urban vs. Rural Pricing for a Brand Name Drug



Source: Medicare.gov, May 17, 2004.

Figure 8c. Urban vs. Rural Pricing for a Diabetes Drug Regimen



Source: Medicare.gov, May 17, 2004

In all cases, Lewin found that rural residents will have the opportunity to choose from the same number of discount cards as urban residents. Furthermore, though there may be fewer pharmacies located in rural areas, rural residents' ability to obtain the same level of savings as urban residents is not affected. The best available price in an urban area almost always equals the best available price in a rural area, and the best available price is obtained through the same discount card sponsor in all areas. This is consistent with our findings that best available price does not vary geographically and that savings are determined by the choice of a discount card and are independent of pharmacy. The sole exception to this finding is in the case that the best available price in an urban market is available through a chain pharmacy-sponsored discount card at the sponsor's pharmacies; if the chain does not have a store in the rural area, the rural best available price will be slightly higher and available through an alternate discount card. Even in such cases, rural residents' savings are not materially diminished. **Tables 4a-4e** in the Appendix provide more detail on the drugs and disease regimens Lewin studied.

C. Variation in Prices at Different Pharmacies

The best available price for the cards examined can generally be obtained at multiple pharmacies, indicating that most beneficiaries will be able to continue shopping at their current preferred pharmacy and still receive the lowest available prices. As an illustration, **Figure 9** compares the price offered by different discount card sponsors for a single commonly prescribed drug at eight pharmacies within a one-mile radius in Chicago.

Figure 9. Variation in Price for a Single Drug at Multiple Pharmacies

Pharmacy	Card 1	Card 2	Card 3	Card 4	Card 5
1 Discount Pharmacy	$81.49	$104.64	$79.44	$80.99	$108.14
2 Chain Pharmacy	$81.49	NA	$79.44	$81.49	NA
3 Independent Pharmacy	$81.49	$104.64	$79.44	$81.49	$108.14
4 Chain Pharmacy - Card Sponsor	$81.99	**$101.42**	$79.44	$80.99	$108.14
5 Discount Pharmacy	$81.49	$104.64	$79.44	$80.99	$108.14
6 Independent Pharmacy	$81.49	$104.64	$79.44	$80.99	$108.14
7 Independent Pharmacy	$81.49	$104.64	$79.44	$81.49	$108.14
8 Independent Pharmacy	$81.49	$104.64	NA	$80.99	$108.14
Maximum Difference	**$0.50**	**$3.22**	**$0.00**	**$0.50**	**$0.00**

Source: Medicare.gov, June 1, 2004

The greatest variation in price is between discount cards. We do find, however, that (as in the example of Card 2 in **Figure 9**) discount cards sponsored by a pharmacy chain offer lower prices at their own pharmacies than at other in-network pharmacies. Beneficiaries who choose such discount cards will achieve greater savings by shopping at the discount card sponsor's pharmacies. Notably, as **Figure 9** illustrates, the use of a drug discount card tends to eliminate the price advantage of discount pharmacies, as discount card sponsors offer the same prices at all types of pharmacies.

IV. AGGREGATE SAVINGS

A. Estimate of National Savings

Total savings from drug discount cards for Medicare beneficiaries nationwide will be driven by the number of beneficiaries who use the discount cards and the individual level of savings expected for the participating population. Estimated average discount levels from drug cards presented earlier in this report are used in this analysis in conjunction with more specific modeling of expected expenditures for the participating Medicare population as well as enrollment projections.

Enrollment levels. Lewin used CMS enrollment projections as a starting point to develop estimates of how many Medicare beneficiaries will elect to use the discount cards. CMS has projected that more than 7 million beneficiaries will enroll in the drug discount card program and that over 4 million (61 percent) will be eligible for the $600 federal credit.[9] There are currently 4 million beneficiaries enrolled in the program, and the CMS Administrator has announced that 25,000 beneficiaries are enrolling daily. In light of the slower than expected initial enrollment figures, we have assumed that full enrollment may not be reached until the end of the year, and our savings estimates reflect this[10].

Using the CMS totals, Lewin developed estimates of enrollment for specific sub-groups of enrollees based on demographic characteristics of Medicare beneficiaries. **Figure 10** shows our estimates for the distribution of enrollment among specific sub-groups of beneficiaries. We assume beneficiaries who have high drug costs are more likely to enroll in the program than others. Similarly, we estimate higher than average participation levels of low-income beneficiaries.

Figure 10. Participating Beneficiaries by Eligibility Group

Eligibility Group	All Participating Beneficiaries	High Cost Participants[1]	Lower Cost Participants (Bottom 80%)[2]	Participants with Diabetes	Participants with Hypertension	Urban (MSA)	Rural (Non -MSA)
	Estimated Number of Participating Beneficiaries Age 65+ (Thousands)						
Card Only (>135% FPL)	2,845	1,144	1,701	652	2,187	1,995	850
Card & $600 Credit (<135% FPL)	4,455	1,250	3,205	927	3,019	3,058	1,397
Total	7,300	2,394	4,906	1,579	5,206	5,053	2,247

[1]High cost beneficiaries are defined as the 20 percent of beneficiaries with the highest prescription drug spending. This 20 percent of beneficiaries accounts for 36 percent of participants because beneficiaries with high drug spending are more likely to participate.
[2]Lower cost beneficiaries are defined as the 80 percent of beneficiaries with the lowest prescription drug spending.

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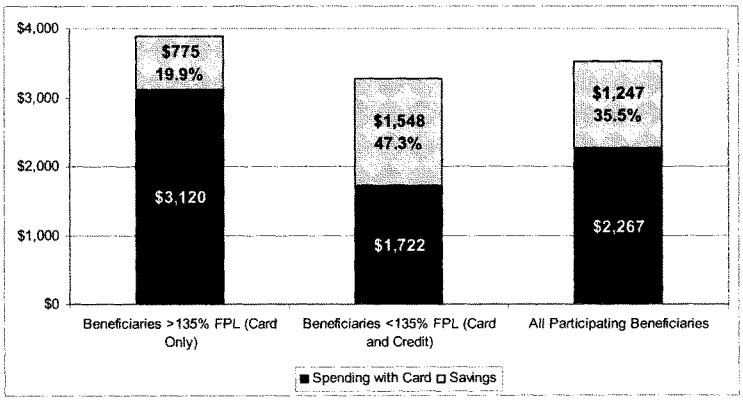
9 Total U.S. participation from CMS Office of the Actuary, published in Federal Register 68(240), December 15, 2003. Lewin estimated the populations of beneficiary subgroups by applying a proprietary Lewin model based on the Medicare Current Beneficiary Survey (MCBS) to CMS projections of total national and state enrollment.

10 We assume that the 4 million already enrolled will be enrolled in the program for an average of 17 months and that the 3.3 million more who are projected to enroll between August and December of this year will be enrolled in the program for an average of 15 months, resulting in a total of 117.5 million member months, or 85 percent of the total potential member months had all beneficiaries been enrolled for the life of the program.

Discount card selection. Our estimates are based on the assumption that beneficiaries will choose a discount card delivering average savings of 19.9 percent, which is the value provided by the 75th percentile card in our market test. This savings level is lower than the savings identified for many common disease regimens, and is substantially lower than the savings available from the best cards. It seems reasonable that beneficiaries will be able to choose discount cards delivering this value using assistance from 1-800-MEDICARE, the price comparison website, or through word of mouth.

Per capita savings. Assuming that beneficiaries choose a card that offers average discounts of 19.9 percent, per capita savings for all beneficiaries over 18 months would average $1,247 or 35.5 percent.[12] The $600 federal credit is included in this average savings. For individuals using the $600 federal credit, savings would be $1,548, while for those using only the discount card savings would be $775 **(Figure 11). Table 5** in the Appendix shows projected per capita savings by income group and for certain subgroups of Medicare beneficiaries over 18 months.

Figure 11. Per Capita Savings by Income Group

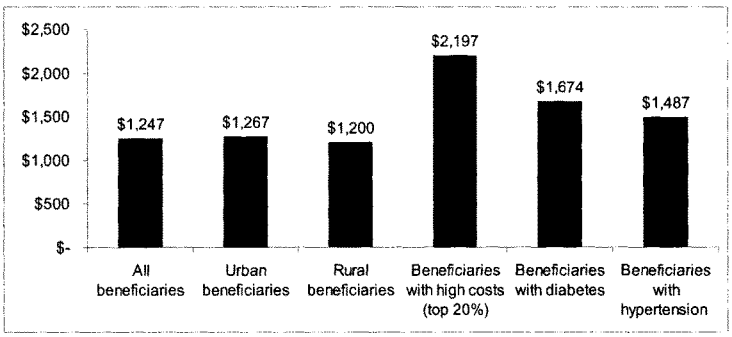


Beneficiaries who experience the highest drug spending today would save the most, with estimated average per capita savings of $2,197 and aggregate savings of $4.5 billion.[13] Low-income beneficiaries with high spending would save about $2.9 billion or $2,766 per capita, and high cost beneficiaries with incomes greater than 135 percent of poverty would save $1.5 billion, about $1,576 per capita.

[12] Per capita spending under the program was compared to per capita baseline spending derived from a proprietary Lewin model which uses data from the 1998 Medicare Current Beneficiary Survey Cost and Use Files trended forward to reflect trends in prices, coverage, and utilization through 2004 and 2005.

[13] "High cost" beneficiaries were identified as those whose annual drug spending put them in the top 20 percent of all beneficiaries.

Figure 12. National Per Capita Beneficiary Savings over 18 Months



Beneficiaries living in urban areas (MSAs), where the majority of the population is concentrated, would save $5.4 billion, or $1,267 on a per capita basis. While the aggregate figure is nearly three times greater than for those beneficiaries living in rural areas, the per capita difference in savings is relatively small.

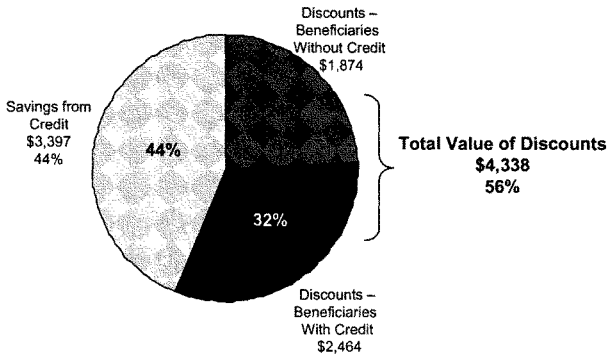
Aggregate savings. In total, we estimate that beneficiaries would achieve savings in excess of $7.7 billion over 18 months if enrollment continues at its current pace and reaches 7.3 million (CMS' projected enrollment) by January 1, 2005[14] and beneficiaries select drug discount cards in the 75th percentile with average savings of 19.9 percent. If aggregate savings are based on the assumption that beneficiaries will choose the very best discount card, delivering 24.4 percent savings, beneficiaries could achieve $8.7 billion in savings. Likewise, if we assume that beneficiaries choose the median discount card, offering 17.2 percent savings off retail prices, beneficiaries could save $7.2 billion in the aggregate.

Our overall savings estimate of $7.7 billion includes savings from price discounts offered by good value discount cards available to all beneficiaries, as well as the $600 federal credit available to low income beneficiaries. It does not, however, include savings that low-income beneficiaries will also receive savings from manufacturer assistance programs associated with the discount cards. As a result, these estimates are likely to understate savings to low-income beneficiaries.

Of the $7.7 billion total savings, 56 percent, or $4.3 billion, is attributable to discounted prescription drug prices and 44 percent, or $3.4 billion, comes from the $600 federal credit available to low income beneficiaries. **Figure 13** shows aggregate savings from the discount cards and $600 federal credit by income group.

[14] Estimated savings from the discounted drug prices available through the discount cards total approximately $145 million per month, while the $600 federal credit available to low-income participants accounts for another $360 million each month. Thus every month beneficiaries delay enrollment in the discount program reduces total savings by millions of dollars.

Figure 13. Aggregate Savings from Discounts and $600 Federal Credit (in millions)



More than 75 percent of the savings accrue to low-income beneficiaries who are able to take advantage of the $600 federal credit in addition to the discounts they receive using a discount card. Aggregate savings estimates for low-income beneficiaries reflect the fact that some beneficiaries with low annual drug expenditures will not use the whole of the $600 federal credit, or $1200 over the life of the program. **Figure 14** shows aggregate baseline spending and aggregate savings for all beneficiaries, by income subgroup, and for selected types of beneficiaries.

Figure 14. National Aggregate Savings with Program

Eligibility Group	All Participating Beneficiaries	High Cost Participants[1]	Lower Cost Participants (Bottom 80%)[2]	Participants with Diabetes	Participants with Hypertension	Urban (MSA)	Rural (Non-MSA)
	Baseline Aggregate Rx Spending over 18 Months (Millions)						
Card Only (>135% FPL)	$11,080	$9,063	$2,017	$3,840	$10,718	$7,686	$3,402
Card & $600 Credit (<135% FPL)	$14,568	$10,402	$4,166	$4,401	$12,487	$10,065	$4,506
Total	$25,648	$19,465	$6,183	$8,241	$23,204	$17,751	$7,909
	Aggregate Savings over 18 Months (Millions)						
Card Only (>135% FPL)	$1,874	$1,533	$341	$649	$1,813	$1,351	$523
Card & $600 Credit (<135% FPL)	$5,861	$2,940	$2,574	$1,598	$4,768	$4,092	$1,768
Total	$7,735	$4,472	$2,915	$2,247	$6,581	$5,443	$2,291

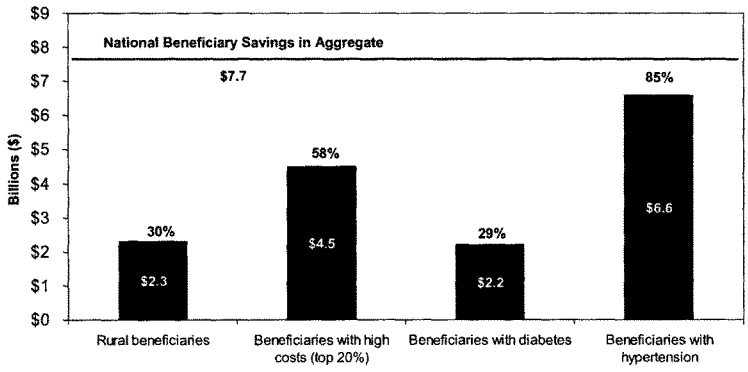
Note: National estimates assume all beneficiaries purchase a typical "value" card, defined as the discount card with the savings level at the 75th percentile of savings.

[1]High cost beneficiaries are defined as the 20 percent of beneficiaries with the highest prescription drug spending. This 20 percent of beneficiaries accounts for 36 percent of participants because beneficiaries with high drug spending are more likely to participate.

[2]Lower cost beneficiaries are defined as the 80 percent of beneficiaries with the lowest prescription drug spending.

Figure 15 below compares savings for specific groups of beneficiaries to the $7.7 billion total savings. Medicare beneficiaries with diabetes are projected to save $2.2 billion in aggregate. A very large number of beneficiaries report having been diagnosed with hypertension, and as a result, we estimate that savings for this group would reach $6.6 billion in aggregate.

Figure 15. Aggregate National Beneficiary Savings over 18 Months for Selected Sub-Populations

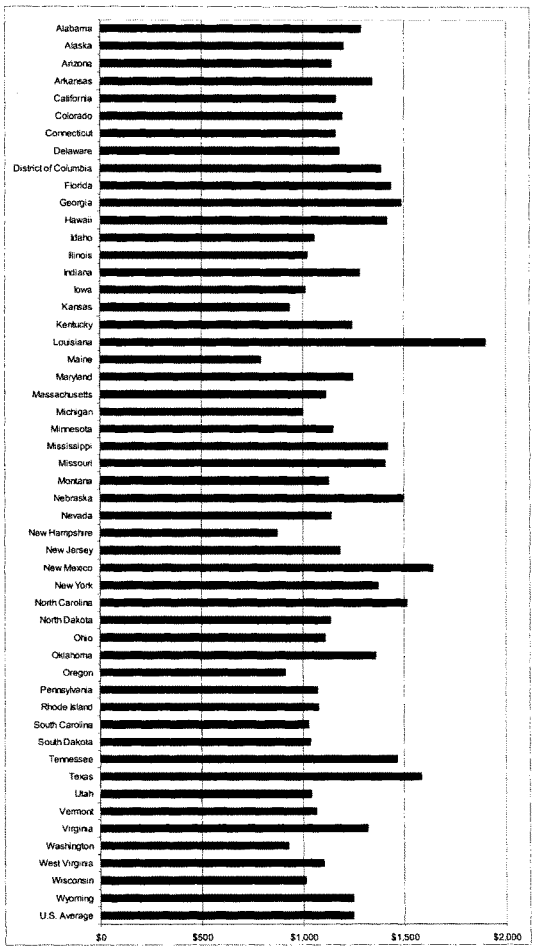


B. Estimates of State-Level Savings

Potential per capita savings range from $795 in Maine to $1,902 in Louisiana (**Figure 16**). The wide range in per capita savings is due both to differences in current retail prices and to the number of low-income beneficiaries eligible for the $600 federal credit. For example, Louisiana's high per capita savings results from the fact that 92 percent of participating beneficiaries are estimated to be eligible for the low-income assistance program. Detailed estimates of state savings are found in **Table 6** in the Appendix.

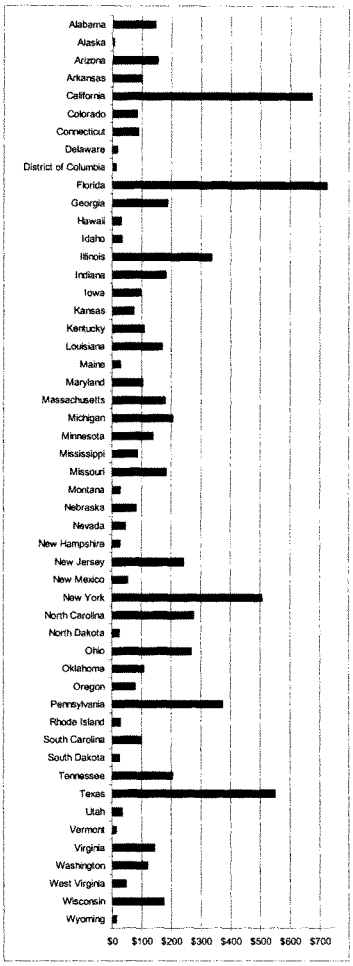
Aggregate savings on a state-by-state basis range from $7.2 million in Alaska to $724.1 million in Florida (**Figure 17**).

Figure 16. Per Capita Savings by State for All Participating Beneficiaries



Note: Assumes all beneficiaries purchase a typical value card, defined as the discount card with the savings level at the 75th percentile of savings. Includes $600 federal credit received by eligible individuals.

Figure 17. Aggregate Savings by State for All Participating Beneficiaries
(in millions of dollars)



Note: Assumes all beneficiaries purchase a typical value card, defined as the discount card with the savings level at the 75th percentile of savings. Aggregate savings includes $600 federal credit for eligible individuals.

V. CONCLUSIONS

Lewin's savings estimates, calculated from conservative benchmark retail prices, suggest that the Medicare drug discount card program can yield $7.7 billion in savings to Medicare beneficiaries who currently pay retail prices. On a per capita basis, the greatest savings would be achieved by high-cost beneficiaries who would save $4.5 billion in aggregate.

Significant discounts are currently available on a wide range of drugs through the discount cards. As many as a quarter of the discount cards offer savings of at least $700 (19.9 percent) off of retail prices over 18 months, and beneficiaries shopping for their individual drug regimens may achieve even greater savings. Average savings across the entire population are $1,247 because of projected high participation levels of low income beneficiaries who can accrue higher savings. Aggregate savings, however, are contingent upon swift enrollment of eligible individuals. Delayed, or unfulfilled, enrollment results in unrecoverable savings.

Appendix A
Tables

Table 1. Best Available Price from Any Discount Card Sponsor Nationally
Table 2. Average Savings for All Discount Cards Offering Top 25 Drugs Nationally
Table 3. Best Available Price for a Top-Selling Hypertension Drug in 20 Markets
Table 4a. Best Available Prices in Urban and Rural Markets in 5 States: Illinois
Table 4b. Best Available Prices in Urban and Rural Markets in 5 States: California
Table 4c. Best Available Prices in Urban and Rural Markets in 5 States: Florida
Table 4d. Best Available Prices in Urban and Rural Markets in 5 States: Texas
Table 4e. Best Available Prices in Urban and Rural Markets in 5 States: New York
Table 5. National Per Capita Savings with Program
Table 6. Average and Aggregate Discount Card Savings over 18 Months by State All Participating Beneficiaries

Table 1. Best Available Price from Any Discount Card Sponsor Nationally

Drug	Drug Name	Brand or Generic	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients over 65 (000s)	Best Available Price		Savings for a 30-Day Supply	
						July	June	$	%
1	Lipitor	B	Statins	Lipid Lowering Agent	57,170	$64.74	$64.67	$7.85	11%
2	Synthroid	B	Thyroid Synthetics	Thyroid conditions	42,162	$11.10	$13.80	$4.91	31%
3	Atenolol	G	Beta Blockers	High blood pressure	39,411	$4.31	$4.64	$9.19	68%
4	Amoxicillin	G	Aminopenicillins	Anti-infectives	37,416	$4.43	$4.43	$8.04	64%
5	Lisinopril	G	ACE Inhibitors	Cardiovascular disease	35,339	$6.86	$7.36	$16.45	71%
6	Hydrochlorothiazide	G	Thiazides	High blood pressure	33,850	$3.14	$3.89	$2.98	49%
7	Furosemide Oral	G	Diuretics	High blood pressure, CHF	33,746	$3.44	$3.44	$2.98	46%
8	Norvasc	B	Calcium Channel Blockers	High blood pressure	29,978	$41.79	$41.79	$5.53	12%
9	Zoloft	B	Anti-depressants	Depression	27,801	$67.59	$67.59	$13.52	17%
10	Zithromax Z-Pak	B	Antibiotics, Macrolide	Anti-infectives	25,418	$41.61	$41.61	$7.14	15%
11	Toprol XL	B	Beta Blockers	High blood pressure	25,268	$19.60	$19.60	$6.11	24%
12	Zocor	B	Statins	Lipid Lowering Agent	24,035	$76.22	$101.42	$60.44	44%
13	Cephalexin	G	Cephalosporins	Anti-infectives	23,750	$23.06	$23.06	$60.62	72%
14	Prevacid	B	Proton Pump Inhibitors	Heartburn, Gastrointestinal	23,383	$110.86	$110.86	$30.27	21%
15	Premarin Tabs	B	Estrogens Oral	Menopause symptoms	22,056	$25.06	$25.30	$4.72	16%
16	Prednisone Oral	G	Corticoids	Anti-inflammatory	21,411	$4.83	$4.83	$8.63	64%
17	Metformin	G	Biguanides	Diabetes	21,321	$14.66	$14.19	$20.65	58%
18	Levoxyl	B	Thyroid Synthetics	Thyroid conditions	21,282	$6.80	$3.65	$6.20	48%
19	Ambien	B	Sedating Non-Benzodiazepine	Insomnia	21,225	$72.75	$73.95	$15.54	18%
20	Allegra	B	Anti-Histamines	Allergy	19,519	$59.23	$59.73	$15.47	21%
21	Celebrex	B	Cox-2 Inhibitors	Pain, Inflammation	19,516	$74.39	$74.39	$14.20	16%
22	Nexium	B	Proton Pump Inhibitors	Heartburn, Gastrointestinal	18,692	$98.99	$98.99	$37.92	28%
23	Metoprolol Tartrate	G	Beta Blockers	High blood pressure	18,465	$4.15	$4.15	$6.45	61%
24	Fosamax	B	Bisphosphonates	Osteoporosis	17,505	$54.90	$55.99	$15.16	22%
25	Zyrtec	B	Anti-Histamines	Allergy	17,241	$55.62	$55.62	$9.68	15%
26	Singulair	B	Leukotriene Agents	Asthma	17,227	$76.59	$77.18	$15.89	17%
27	Vioxx	B	Cox-2 Inhibitors	Pain, Inflammation	17,093	$76.20	$77.70	$14.46	16%
28	Neurontin	B	Seizure Treatments	Seizure Disorders	15,938	$108.66	$108.66	$17.50	14%
29	Viagra	B	Sexual Function Disorder	Erectile Dysfunction	15,207	$255.49	$255.49	$61.73	19%
30	Protonix	B	Proton Pump Inhibitors	Heartburn, Gastrointestinal	14,028	$86.03	$86.03	$24.98	23%
31	Plavix	B	Anitplatelets	Reduce risk of stroke	13,786	$108.39	$108.39	$17.96	14%

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 1. Best Available Price from Any Discount Card Sponsor Nationally (continued)

Drug	Drug Name	Brand or Generic	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients over 65 (000s)	Best Available Price		Savings for a 30-Day Supply	
						July	June	$	%
32	Pravachol	B	Statins	Lipid Lowering Agent	13,312	$106.80	$106.80	$27.25	20%
33	Trazodone HCl	G	New Generation Anti-depressant	Depression	13,165	$3.59	$4.09	$7.63	68%
34	Lexapro	B	Anti-depressants	Depression	13,070	$59.39	$59.23	$10.80	15%
35	Levaquin	B	Quinolones	Anti-infectives	12,608	$240.57	$240.57	$74.32	24%
36	Enalapril	G	ACE Inhibitors	Cardiovascular disease	12,488	$5.20	$5.70	$19.05	79%
37	Naproxen	G	Anti-Arthritics	Pain, Inflammation	12,204	$11.13	$11.13	$29.84	73%
38	Accupril	B	ACE Inhibitors	Cardiovascular disease	11,427	$32.60	$32.60	$5.54	15%
39	Altace	B	ACE Inhibitors	Cardiovascular disease	10,703	$44.32	$44.32	$9.42	18%
40	Diflucan	B	Triazoles	Anti-Fungal	10,671	$372.27	$372.27	$134.93	27%
41	Diovan	B	Angiotensin II Receptor Blockers	High blood pressure	10,578	$43.15	$43.31	$6.93	14%
42	Lotrel	B	ACE Inhibitors	Cardiovascular disease	10,417	$63.63	$63.85	$6.87	10%
43	Glucotrol XL	B	Sulfonylureas	Diabetes	9,958	$49.36	$49.36	$5.82	11%
44	Verapamil SR	G	Calcium Channel Blockers	High blood pressure	9,439	$17.50	$18.00	$14.19	45%
45	Clarinex	B	Anti-Histamines	Allergy	9,316	$65.62	$65.62	$7.34	10%
46	Bextra	B	Cox-2 Inhibitors	Pain, Inflammation	9,210	$78.30	$78.30	$17.83	19%
47	Doxycycline	G	Tetracyclines	Anti-infectives	9,147	$8.11	$8.81	$43.06	84%
48	Glyburide	G	Sulfonylureas	Diabetes	8,816	$5.63	$12.39	$6.76	55%
49	Allopurinol	G	Gout Specifics	Gout, certain kidney stones	8,507	$5.23	$5.68	$8.51	62%
50	Clonidine	G	Central Act (alpha agonist)	High blood pressure	8,486	$4.44	$5.27	$10.12	70%
51	Cozaar	B	Angiotensin II Receptor Blockers	High blood pressure	8,280	$38.13	$40.83	$10.72	22%
52	Actos	B	Insulin Sensitizers	Diabetes	8,272	$134.53	$134.53	$28.30	17%
53	Diovan HCT	B	Angiotensin II Receptor Blockers	High blood pressure	8,074	$49.32	$49.32	$9.72	16%
54	Avandia	B	Insulin Sensitizers	Diabetes	7,916	$73.41	$73.89	$12.82	15%
55	Cipro	B	Quinolones	Anti-infectives	7,897	$306.98	$306.98	$39.18	11%
56	Risperdal	B	Anti-Psychotics	Phsychiatric Disorders	7,894	$172.39	$173.27	$34.34	17%
57	Coumadin Tabs	B	Anticoagulants	Blood Clot prevention	7,827	$20.10	$20.10	$6.62	25%
58	Lisinopril/HCTZ	G	ACE Inhibitors	Cardiovascular disease	7,664	$10.90	$11.40	$18.48	63%
59	Aciphex	B	Proton Pump Inhibitors	Heartburn, Gastrointestinal	7,405	$111.72	$112.30	$22.36	17%
60	Lotensin	B	ACE Inhibitors	Cardiovascular disease	7,115	$32.03	$32.03	$3.63	10%
61	Flomax	B	Benign Prostate Disease	Prostate Disease	7,092	$52.48	$52.48	$9.87	16%
62	Amoxil	B	Aminopenicillins	Anti-infectives	7,056	$7.67	$7.67	$21.85	74%

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 1. Best Available Price from Any Discount Card Sponsor Nationally (continued)

Drug	Drug Name	Brand or Generic	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients over 65 (000s)	Best Available Price		Savings for a 30-Day Supply	
						July	June	$	%
63	Glucophage XR	B	Biguanides	Diabetes	7,049	$47.48	$47.48	$2.63	5%
64	Lanoxin	B	Inotropics	Heart failure	6,923	$6.01	$6.31	$2.82	32%
65	OxyContin	B	Codeines	Pain	6,889	$168.68	$180.57	$10.89	6%
66	Evista	B	Bone Density Reg, Other	Osteoporosis	6,479	$66.99	$66.99	$12.55	16%
67	Hyzaar	B	Angiotensin II Receptor Blockers	High blood pressure	6,265	$37.42	$40.12	$11.44	23%
68	Amaryl	B	Sulfonylureas	Diabetes	6,260	$27.59	$27.59	$5.57	17%
69	Actonel	B	Bisphosphonates	Osteoporosis	6,218	$42.36	$42.36	$9.48	18%
70	Tricor	B	Fibric Acid Derivative	Lipid Lowering Agent	6,193	$83.70	$83.78	$8.55	9%
71	Glucovance	B	Diabetes Orals	Diabetes	6,192	$89.66	$89.65	$4.51	5%
72	Meclizine HCl	G	Anti-Nausea Anti-Histamine	Motion Sickness symptoms	5,615	$5.43	$5.43	$13.20	71%
73	Ultracet	B	Syn Non-narcotic non-injectable	Pain	4,938	$127.10	$128.39	$35.41	22%
74	Zithromax	B	Antibiotics, Macrolide	Anti-infectives	4,868	$198.72	$226.66	$45.89	19%
75	Prilosec	B	Proton Pump Inhibitors	Heartburn, Gastrointestinal	4,844	$105.74	$105.74	$30.56	22%
76	Avapro	B	Angiotensin II Receptor Blockers	High blood pressure	4,721	$40.29	$41.04	$10.68	21%
77	Coreg	B	Alpha-Beta Blockers	High blood pressure	4,687	$89.56	$90.06	$18.93	17%
78	Glipizide	G	Sulfonylureas	Diabetes	4,652	$6.02	$6.02	$10.54	64%
79	Detrol LA	B	Antispas Urinary Tract	Bladder conditions	4,640	$81.91	$81.91	$10.50	11%
80	Omnicef	B	Cephalosporins	Anti-infectives	4,616	$225.46	$225.46	$50.10	18%
81	Terazosin	G	Alpha Blockers	High blood pressure	4,557	$10.53	$11.03	$26.83	72%
82	Macrobid	B	Urinary Tract Anti-Infective, Other	Anti-infective	4,541	$120.28	$112.28	$20.34	14%
83	Zetia	B	Cholesterol Absorption Inhibitors	Lipid Lowering Agent	4,366	$69.58	$69.58	$5.68	8%
84	Monopril	B	ACE Inhibitors	Cardiovascular disease	4,322	$36.57	$36.57	$4.68	11%
85	Aricept	B	Alzheimer's Disease	Alzheimer's Disease	3,482	$126.42	$126.42	$22.95	15%
86	Ditropan XL	B	Antispas Urinary Tract	Bladder conditions	3,287	$81.66	$81.66	$12.77	14%
87	Tamoxifen	G	Anti-Neoplasmic Anti-Estrogens	Breast Cancer	3,111	$26.80	$34.50	$76.37	75%
88	Methotrexate	G	Folic Acid Analog	Cancer, psoriasis, arthritis	3,109	$22.00	$22.00	$50.30	70%
89	Tetracycline	G	Tetracyclines	Anti-infectives	3,046	$5.99	$5.99	$6.14	51%
90	Mobic	B	Anti-Arthritics	Pain, Inflammation	2,880	$74.68	$74.68	$8.69	10%
91	Atacand	B	Angiotensin II Receptor Blockers	High blood pressure	2,767	$35.70	$36.20	$11.36	24%
92	Biaxin	B	Antibiotics, Macrolide	Anti-infectives	2,728	$235.82	$229.99	$30.09	11%
93	Digoxin	G	Inotropics	Heart failure	2,598	$5.61	$5.81	$3.27	37%

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 1. Best Available Price from Any Discount Card Sponsor Nationally (continued)

Drug	Drug Name	Brand or Generic	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients over 65 (000s)	Best Available Price		Savings for a 30-Day Supply	
						July	June	$	%
94	Avalide	B	Angiotensin II Receptor Blockers	High blood pressure	2,482	$49.20	$49.95	$13.69	22%
95	Augmentin XR	B	Increased B-Lactam Act	Anti-infectives	2,461	$214.99	$215.49	$45.87	18%
96	Lamisil Oral	B	Allylamines	Anti-Fungal	2,413	$261.62	$263.59	$34.39	12%
97	Proscar	B	Benign Prostate Disease	Prostate Disease	2,374	$74.20	$71.58	$9.05	11%
98	Colchicine	G	Gout Specifics	Gout, certain kidney stones	2,254	$7.07	$7.07	$10.68	60%
99	Tiazac	B	Calcium Channel Blockers	High blood pressure	2,184	$52.08	$57.05	$10.43	17%
100	Tequin	B	Quinolones	Anti-infectives	2,180	$256.40	$256.40	$33.13	11%
101	Benicar	B	Angiotensin II Receptor Blockers	High blood pressure	2,097	$39.55	$39.52	$3.78	9%
102	Zantac	B	H2 Antagonists	Heartburn, Gastrointestinal	1,748	$113.94	$114.21	$12.16	10%
103	Augmentin	B	Increased B-Lactam Act	Anti-infectives	1,686	$296.47	$294.04	$43.13	13%
104	Glucophage	B	Biguanides	Diabetes	1,680	$68.03	$22.68	$7.89	10%
105	Zestril	B	ACE Inhibitors	Cardiovascular disease	1,445	$27.32	$27.32	$9.23	25%
106	Pletal	B	Hemostatics, Other Oral	Improve Blood Circulation	1,417	$93.23	$86.48	$17.03	15%
107	Prozac	B	Anti-depressants	Depression	1,404	$210.72	$204.84	$0.64	0%
108	Famvir	B	Anti-Virals	Viral Infections	1,263	$432.37	$437.55	$48.82	10%
109	Cipro XR	B	Quinolones	Anti-infectives	1,137	$215.62	$216.24	$60.39	22%
110	Lasix Oral	B	Diuretics	High blood pressure, CHF	1,126	$7.44	$7.44	$4.10	36%
111	Xanax	B	Benzodiazepines	Anxiety	1,116	EXCLUDED	$106.83	NA	NA
112	Exelon	B	Alzheimer's Disease	Alzheimer's Disease	1,100	$140.32	$140.32	$16.41	10%
113	Mirapex	B	Anti-Parkinson Other	Parkinson's Disease	1,092	$70.28	$70.28	$7.68	10%
114	Cardizem CD	B	Calcium Channel Blockers	High blood pressure	1,048	$64.51	$64.51	$9.66	13%
115	Avandamet	B	Diabetes Orals	Diabetes	950	$125.72	$126.84	$30.01	19%
116	Reminyl	B	Alzheimer's Disease	Alzheimer's Disease	848	$130.38	$130.38	$24.78	16%
117	Flexeril	B	Muscle Relaxant w/o Analg	Muscle Spasms	803	$63.35	$63.35	$18.19	22%
118	Dyazide	B	Diuretics	High blood pressure, CHF	799	$15.17	$15.17	$3.57	19%
119	Prinivil	B	ACE Inhibitors	Cardiovascular disease	762	$29.13	$29.13	$6.51	18%
120	Procardia XL	B	Calcium Channel Blockers	High blood pressure	740	$43.44	$43.44	$5.29	11%
121	Adalat CC	B	Calcium Channel Blockers	High blood pressure	739	$41.79	$41.79	$3.71	8%
122	Ultram	B	Syn Non-narcotic non-injectable	Pain	732	$115.37	$115.37	$21.00	15%
123	Darvocet-N-100	B	Propoxyphenes	Pain	716	$112.81	$112.81	$13.57	11%
124	Percocet-5	B	Codeines	Pain	567	$197.64	$71.14	$8.72	4%

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 1. Best Available Price from Any Discount Card Sponsor Nationally (continued)

Drug	Drug Name	Brand or Generic	Therapeutic Class	Used to Treat	Number of Rx Sold to Patients over 65 (000s)	Best Available Price		Savings for a 30-Day Supply	
						July	June	$	%
125	Ativan	B	Benzodiazepines	Anxiety	596	EXCLUDED	$197.64	NA	NA
126	Tenormin	B	Beta Blockers	High blood pressure	562	$32.64	$32.64	$8.53	21%
127	Cardizem LA	B	Calcium Channel Blockers	High blood pressure	555	$40.29	$38.30	$8.39	17%
128	Zestoretic	B	ACE Inhibitors	Cardiovascular disease	495	$33.30	$33.30	$11.08	25%
129	Lopressor	B	Beta Blockers	High blood pressure	482	$57.44	$57.44	$3.18	5%
130	Cardura	B	Alpha Blockers	High blood pressure	460	$34.21	$34.21	$4.22	11%
131	Crestor	B	Statins	Lipid Lowering Agent	416	$62.42	$60.30	$18.26	23%
132	Vantin	B	Cephalosporins	Anti-infectives	401	$317.00	$317.00	$16.71	5%
133	Vasotec	B	ACE Inhibitors	Cardiovascular disease	385	$31.06	$31.06	$6.11	16%
134	Ziac	B	Beta/Alpha-Beta Blockers/Diuretic	High blood pressure	379	$39.02	$39.02	$4.62	11%
135	Phenergan Tabs	B	Anti-Nausea Apti-Dopa Pheno	Nausea, vomiting	372	$30.11	$30.11	$39.32	57%
136	Imdur	B	Nitrites	Cardiovascular disease	325	$57.04	$57.04	$5.27	8%
137	Maxzide 25	B	Diuretics	High blood pressure, CHF	324	$15.23	$15.23	$5.70	27%
138	Calan SR	B	Calcium Channel Blockers	High blood pressure	288	$60.13	$60.13	$2.87	5%
139	Hytrin	B	Alpha Blockers	High blood pressure	282	$59.54	$59.54	$4.74	7%
140	Tylenol #3	B	Codeines	Pain	282	$19.17	$17.43	$8.80	31%
141	Pepcid	B	H2 Antagonists	Heartburn, Gastrointestinal	270	$105.68	$105.68	$17.74	14%
142	Prinzide	B	ACE Inhibitors	Cardiovascular disease	235	$35.60	$35.60	$7.23	17%
143	Motrin	B	Anti-Arthritics	Pain, Inflammation	222	$40.05	$40.05	$4.27	10%
144	Maxzide	B	Diuretics	High blood pressure, CHF	158	$30.85	$30.85	$10.99	26%
145	Septra DS	B	Sulfnmd&trimeth w/ cmb	Anti-infectives	149	$68.01	$68.00	$18.29	21%
146	Sinemet CR	B	Anti-Parkinson L-Dopa	Parkinson's Disease	147	$141.65	$141.65	$38.74	21%
147	Mevacor	B	Statins	Lipid Lowering Agent	143	$69.48	$69.48	$9.05	12%
148	Sinemet	B	Anti-Parkinson L-Dopa	Parkinson's Disease	95	$91.25	$90.96	$22.63	20%
149	Keflex	B	Cephalosporins	Anti-infectives	89	$256.22	$255.66	$53.69	17%
150	Naprosyn	B	Anti-Arthritics	Pain, Inflammation	69	$91.75	$91.75	$16.47	15%
				Savings Per Prescription				**$17.37**	**23.2%**
				Contribution From Brand Prescription				**$12.68**	**18.6%**
				Contribution From Generic Prescription				**$4.68**	**67.5%**

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 2. Average Savings for All Discount Cards Offering Top 25 Drugs Nationally

Card	Average Price Per Prescription with Discount Card		Average Savings Per Prescription		Percent Savings (July)	Per Capita Savings over 18 Months (June)
	July	June	July	June		
Card 1	$37.23	$37.15	$12.04	$12.11	24.4%	$858.34
Card 2	$37.29	$37.63	$11.97	$11.64	24.3%	$853.52
Card 3	$37.39		$11.87		24.1%	$846.64
Card 4	$38.74	$39.45	$10.52	$9.82	21.4%	$750.23
Card 5	$39.05	$39.75	$10.22	$9.51	20.7%	$728.49
Card 6	$39.06	$39.77	$10.20	$9.49	20.7%	$727.32
Card 7	$39.34	$42.43	$9.92	$6.83	20.1%	$707.39
Card 8	$39.47	$39.43	$9.80	$9.84	19.9%	$698.64
Card 9	$39.47	$39.43	$9.80	$9.84	19.9%	$698.64
Card 10	$39.62	$45.14	$9.65	$4.12	19.6%	$687.84
Card 11	$39.62	$45.14	$9.65	$4.12	19.6%	$687.84
Card 12	$40.00	$40.16	$9.26	$9.10	18.8%	$660.61
Card 13	$40.01	$40.27	$9.25	$8.99	18.8%	$659.68
Card 14	$40.01	$40.27	$9.25	$8.99	18.8%	$659.68
Card 15	$40.79		$8.48		17.2%	$604.38
Card 16	$40.79		$8.48		17.2%	$604.38
Card 17	$40.79		$8.48		17.2%	$604.38
Card 18	$40.79		$8.48		17.2%	$604.38
Card 19	$40.79		$8.48		17.2%	$604.38
Card 20	$40.79		$8.48		17.2%	$604.38
Card 21	$40.90		$8.36		17.0%	$596.39
Card 22	$41.11		$8.15		16.5%	$581.09
Card 23	$41.32		$7.94		16.1%	$566.14
Card 24	$41.57		$7.69		15.6%	$548.38
Card 25	$41.91		$7.35		14.9%	$524.26
Card 26	$41.91		$7.35		14.9%	$524.26
Card 27	$41.98		$7.28		14.8%	$519.31
Card 28	$42.15	$41.92	$7.11	$7.35	14.4%	$507.22
Card 29	$42.23		$7.03		14.3%	$501.55
Card 30	$43.57	$41.87	$5.70	$7.40	11.6%	$406.21
Card 31	$43.77		$5.49		11.2%	$391.77
Card 32	$43.77	$43.52	$5.49	$5.74	11.2%	$391.76
Card 33	$43.79	$43.54	$5.48	$5.73	11.1%	$390.49
Card 34	$43.86	$42.10	$5.40	$7.17	11.0%	$385.23

Note: Data collected in zip code 60619 in Chicago, IL. Savings calculated off National Retail Benchmark.

Table 3. Best Available Price for a Top-Selling Hypertension Drug in 20 Markets

State	State Benchmark Price	Best Available Price with Discount Card	Savings	
			$	%
AK	$53.08	$46.00	$7.08	13%
AL	$51.54	$45.57	$5.97	12%
AZ	$54.30	$46.00	$8.30	15%
CA	$53.54	$46.00	$7.54	14%
CO	$53.54	$46.00	$7.54	14%
DC	$51.63	$46.00	$5.63	11%
FL	$55.72	$46.00	$9.72	17%
GA	$53.27	$46.00	$7.27	14%
IA	$53.15	$46.00	$7.15	13%
IL	$55.25	$46.00	$9.25	17%
IN	$52.79	$46.00	$6.79	13%
LA	$56.07	$46.00	$10.07	18%
MA	$52.61	$46.00	$6.61	13%
MT	$53.15	$46.00	$7.15	13%
NC	$53.60	$46.00	$7.60	14%
NY	$54.02	$46.00	$8.02	15%
OH	$51.73	$46.00	$5.73	11%
PA	$51.86	$46.00	$5.86	11%
TN	$53.30	$46.00	$7.30	14%
TX	$54.84	$45.57	$9.27	17%
WA	$54.20	$46.00	$8.20	15%

Note: Data collected week of April 30, 2004

Table 4a. Best Available Prices in Urban and Rural Markets in 5 States: Illinois

Drug(s)	Brand or Generic	Chicago, IL		Marion, IL		Best Price Offered by Same Card in Both Markets
		Best Price	Cards Available	Best Price	Cards Available	
Thyroid Synthetic	B	$13.80	30	$13.80	30	Yes
Anti-Depressant	B	$69.99	30	$69.99	30	Yes
Proton Pump Inhibitor	B	$110.86	30	$110.86	30	Yes
Diuretic	G	$3.44	27	$3.44	27	Yes
Anti-Depressant	G	$4.09	30	$4.09	30	Yes
Biguanide	G	$8.84	30	$8.84	30	Yes
Diabetes Regimen	NA	$211.15	30	$213.41	30	Yes
Hypertension Regimen	NA	$57.02	30	$57.02	30	Yes
Multiple Chronic Regimen	NA	$514.36	30	$514.36	30	Yes

Note: Data collected May 17, 2004.

Table 4b. Best Available Prices in Urban and Rural Markets in 5 States: California

Drug(s)	Brand or Generic	Los Angeles, CA		Susanville, CA		Best Price Offered by Same Card in Both Markets
		Best Price	Cards Available	Best Price	Cards Available	
Thyroid Synthetic	B	$13.80	27	$14.93	27	No
Anti-Depressant	B	$69.99	27	$71.69	27	No
Proton Pump Inhibitor	B	$110.86	26	$112.17	26	No
Diuretic	G	$3.44	24	$3.44	24	Yes
Anti-Depressant	G	$4.09	27	$4.09	27	Yes
Biguanide	G	$8.84	27	$8.84	27	Yes
Diabetes Regimen	NA	$211.15	26	$211.15	26	Yes
Hypertension Regimen	NA	$57.02	27	$57.02	27	Yes
Multiple Chronic Regimen	NA	$514.36	26	$524.29	26	No

Note: Data collected May 17, 2004.

Table 4c. Best Available Prices in Urban and Rural Markets in 5 States: Florida

Drug(s)	Brand or Generic	Tampa, FL		Perry, FL		Best Price Offered by Same Card in Both Markets
		Best Price	Cards Available	Best Price	Cards Available	
Thyroid Synthetic	B	$14.76	28	$14.76	28	Yes
Anti-Depressant	B	$74.36	28	$74.36	28	No
Proton Pump Inhibitor	B	$112.17	28	$112.17	28	Yes
Diuretic	G	$3.44	24	$3.44	24	Yes
Anti-Depressant	G	$4.09	28	$4.09	28	Yes
Biguanide	G	$8.84	28	$8.84	28	Yes
Diabetes Regimen	NA	$211.15	28	$211.15	28	Yes
Hypertension Regimen	NA	$57.02	28	$57.02	28	Yes
Multiple Chronic Regimen	NA	$524.29	28	$524.29	28	Yes

Note: Data collected May 17, 2004.

Table 4d. Best Available Prices in Urban and Rural Markets in 5 States: Texas

Drug(s)	Brand or Generic	Dallas, TX		Snyder, TX		Best Price Offered by Same Card in Both Markets
		Best Price	Cards Available	Best Price	Cards Available	
Thyroid Synthetic	B	$13.80	30	$14.76	30	No
Anti-Depressant	B	$69.99	30	$71.69	30	No
Proton Pump Inhibitor	B	$110.86	29	$112.17	29	No
Diuretic	G	$3.44	27	$3.44	27	Yes
Anti-Depressant	G	$4.09	30	$4.09	30	Yes
Biguanide	G	$8.84	30	$8.84	30	Yes
Diabetes Regimen	NA	$211.15	28	$211.15	28	Yes
Hypertension Regimen	NA	$57.02	30	$57.02	30	Yes
Multiple Chronic Regimen	NA	$521.43	28	$524.29	28	No

Note: Data collected May 17, 2004.

Table 4e. Best Available Prices in Urban and Rural Markets in 5 States: New York

Drug(s)	Brand or Generic	Nassau, NY		Salamanca, NY		Best Price Offered by Same Card in Both Markets
		Best Price	Cards Available	Best Price	Cards Available	
Thyroid Synthetic	B	$13.76	28	$14.76	28	Yes
Anti-Depressant	B	$74.52	28	$74.36	28	No
Proton Pump Inhibitor	B	$112.17	28	$112.17	28	Yes
Diuretic	G	$3.44	25	$3.44	25	Yes
Anti-Depressant	G	$4.09	28	$4.09	28	Yes
Biguanide	G	$8.84	28	$8.84	28	Yes
Diabetes Regimen	NA	$211.15	28	$211.15	28	Yes
Hypertension Regimen	NA	$57.02	28	$57.02	28	Yes
Multiple Chronic Regimen	NA	$522.47	28	$524.29	28	No

Note: Data collected May 17, 2004.

Table 5. National Per Capita Savings with Program

Eligibility Group	All Participating Beneficiaries	High Cost Participants[1]	Lower Cost Participants (Bottom 80%)[2]	Participants with Diabetes	Participants with Hypertension	Urban (MSA)	Rural (Non-MSA)
	Baseline Rx Spending Per Participant Age 65+ over 18 Months						
Card Only (>135% FPL)	$3,895	$7,920	$1,186	$5,887	$4,900	$3,853	$4,002
Card & $600 Credit (<135% FPL)	$3,270	$8,321	$1,300	$4,749	$4,136	$3,291	$3,226
Total	$3,513	$8,129	$1,260	$5,211	$4,451	$3,513	$3,520
	Savings Per Participating Beneficiary over 18 Months						
Card Only (>135% FPL)	$775	$1,576	$236	$1,172	$975	$797	$724
Card & $600 Credit (<135% FPL)	$1,548	$2,766	$945	$2,028	$1,858	$1,574	$1,489
Total	$1,247	$2,197	$699	$1,674	$1,487	$1,267	$1,200

Note: National estimates assume all beneficiaries purchase a typical "value" card, defined as the discount card with the savings level at the 75th percentile of savings.
[1]High cost beneficiaries are defined as the 20 percent of beneficiaries with the highest prescription drug spending. This 20 percent of beneficiaries accounts for 36 percent of participants because beneficiaries with high drug spending are more likely to participate.
[2]Lower cost beneficiaries are defined as the 80 percent of beneficiaries with the lowest prescription drug spending.

Table 6. Average and Aggregate Discount Card Savings over 18 Months by State
All Participating Beneficiaries

	Per Capita Retail Spending without Card	Per Capita Savings under Program		Number of Participating Beneficiaries (000)	Aggregate Savings (millions)
		$	%		
U.S. TOTAL	**$3,513**	**$1,247**	**35.5%**	**7,300**	**$7,735.7**
Alabama	$3,359	$1,287	38.3%	142	$144.6
Alaska	$3,391	$1,201	35.4%	7	$7.2
Arizona	$3,620	$1,144	31.6%	147	$152.8
Arkansas	$3,479	$1,344	38.6%	92	$100.6
California	$3,450	$1,166	33.8%	679	$671.9
Colorado	$3,530	$1,197	33.9%	82	$84.2
Connecticut	$3,476	$1,162	33.4%	90	$89.2
Delaware	$3,373	$1,182	35.1%	17	$17.0
District of Columbia	$3,346	$1,386	41.4%	12	$12.4
Florida	$3,797	$1,437	37.8%	580	$724.1
Georgia	$3,507	$1,488	42.4%	159	$186.5
Hawaii	$3,598	$1,417	39.4%	26	$30.6
Idaho	$3,444	$1,057	30.7%	37	$34.6
Illinois	$3,755	$1,023	27.3%	326	$336.2
Indiana	$3,487	$1,282	36.8%	172	$183.0
Iowa	$3,485	$1,015	29.1%	105	$97.1
Kansas	$3,450	$937	27.2%	85	$74.4
Kentucky	$3,432	$1,244	36.2%	106	$108.6
Louisiana	$3,751	$1,902	50.7%	116	$168.7
Maine	$3,136	$795	25.4%	43	$29.7
Maryland	$3,387	$1,250	36.9%	103	$104.4
Massachusetts	$3,437	$1,116	32.5%	187	$179.5
Michigan	$3,365	$1,001	29.8%	234	$205.4
Minnesota	$3,559	$1,152	32.4%	136	$139.0
Mississippi	$3,532	$1,421	40.2%	76	$86.7
Missouri	$3,627	$1,408	38.8%	156	$183.4
Montana	$3,474	$1,129	32.5%	30	$29.2
Nebraska	$3,752	$1,494	39.8%	66	$82.5
Nevada	$3,444	$1,144	33.2%	48	$46.9
New Hampshire	$3,262	$875	26.8%	35	$27.1
New Jersey	$3,588	$1,185	33.0%	233	$244.0
New Mexico	$3,780	$1,641	43.4%	41	$54.7
New York	$3,581	$1,371	38.3%	445	$505.8
North Carolina	$3,581	$1,515	42.3%	229	$277.1
North Dakota	$3,427	$1,136	33.1%	26	$25.3
Ohio	$3,323	$1,112	33.5%	291	$267.4
Oklahoma	$3,577	$1,360	38.0%	97	$109.5
Oregon	$3,370	$914	27.1%	94	$78.3
Pennsylvania	$3,390	$1,075	31.7%	406	$374.7
Rhode Island	$3,183	$1,079	33.9%	36	$30.5
South Carolina	$3,490	$1,029	29.5%	108	$100.7
South Dakota	$3,322	$1,037	31.2%	29	$25.6
Tennessee	$3,570	$1,466	41.1%	173	$204.5
Texas	$3,676	$1,584	43.1%	431	$549.9
Utah	$3,270	$1,042	31.9%	41	$35.2
Vermont	$3,261	$1,066	32.7%	16	$14.0
Virginia	$3,397	$1,322	38.9%	136	$142.8
Washington	$3,504	$927	26.4%	136	$121.0
West Virginia	$3,273	$1,104	33.7%	52	$47.0
Wisconsin	$3,757	$1,013	27.0%	170	$175.0
Wyoming	$3,435	$1,248	36.3%	15	$14.9

Note: State estimates assume all beneficiaries purchase a typical "value" card, defined as the discount card with the savings level at the 75th percentile of savings. Total U.S. participation from CMS Office of the Actuary. State-level estimates derived by applying unpublished state distribution of number of beneficiaries without drug coverage (also from CMS OACT) to U.S. card participation estimates. U.S. totals from OACT published in Federal Register 68(240), December 15, 2003. Savings assumes enrollment will be reached by January 1, 2005.

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